10

EPSDT STATUS

A REVIEW OF EIGHT STATES

SRS-74-63

DECEMBER 1974

BOKONON SYSTEMS, INC.

2000 P STREET, N.W. • SUITE 612 • WASHINGTON, D.C. 20036 • 202 - 223-2558

EPSDT STATUS

A REVIEW OF EIGHT STATES

SRS-74-63

DECEMBER 1974

BOKONON SYSTEMS, INC.

2000 P STREET, N.W. • SUITE 612 • WASHINGTON, D.C. 20036 • 202 - 223-2558

EPSDT STATUS

A REVIEW OF EIGHT STATES

PURPOSE: AS PART OF AN EFFORT DESIGNED TO DEVELOP A MODEL FOR EVALUATION OF EPSDT, EIGHT STATES WERE VISITED TO DETERMINE PRESENT PROGRAM STATUS. IN PARTICULAR THE OBJECTIVES OF THESE STATE VISITS WERE:

- TO DESCRIBE INPLACE EPSDT EFFORTS
- TO DETERMINE WHAT DATA ARE BEING RECORDED AND STORED
- TO DETERMINE WHAT USES ARE BEING MADE OF THIS DATA FOR MONITORING, EVALUATION AND PLANNING

DATA WAS ANALYZED AND TABLED IN THE FOLLOWING WAYS:

- STATE INFORMATION FLOW CHARTS
  A DESCRIPTION OF ACTIVITIES AND DATA FILES INPLACE TO SUPPORT THOSE ACTIVITIES.
- STATE COMPONENT MATRIX
  A LISTING OF PROGRAM COMPONENTS BY STATE.
- STATE DATA FILE MATRIX
  A LISTING OF DATA FILES BY STATE.

ACTIVITIES EVIDENCED IN THE STATES WERE ALSO DESCRIBED IN NARRATIVE FORM.

IT WAS FOUND THAT STATES WERE PURSUING EFFORTS TO CARRY OUT EPSDT REQUIREMENTS AND IN DOING SO HAD DEVELOPED SOPHISTICATED DATA FILES. HOWEVER, DUE TO THE PRESSURE TO IMPLEMENT EPSDT, VERY LITTLE ATTENTION IS BEING PAID TO THE USE OF THIS DATA FOR MONITORING, EVALUATION OR PLANNING.

THIS REPORT WILL SERVE AS THE FOCUS FOR THE DEVELOPMENT OF AN EVALUATION MODEL BASED ON A CONCEPT OF DATA CLASSIFICATION WHICH WILL PERMIT PRESENT STATE DATA FILES TO BE ACCESSED FOR EVALUATIVE PURPOSES.

TABLE OF CONTENTS

APPENDICES

1.0 SUMMARY

To provide the poor and medically needy with access to health care and thereby improve their health status, Federal programs provide services (Title V) or financing (Title XVIII and XIX). Early Periodic Screening, Diagnosis and Treatment, mandated under 1968 Amendments to Title XIX, is unique insofar as it is a financing program whose legislation mandates direct services to eligible pediatric populations.

The difficulties inherent in implementing such a program are further compounded by the state option in Title XIX which permits states to determine the extent of their participation. The result is that EPSDT plans are packages of benefits and restrictions tailored to the objectives of individual states. Accordingly, what has been obtained is state by state EPSDT development accompanied by unique data collection and storage procedures.

The wide range of EPSDT data systems constitutes a difficult problem for planning and policy making since it makes comparison of different programs difficult if not impossible. The development of an evaluation model which would require precisely the same data collected within each state would create an incredible burden both in time and cost. Furthermore, the success of such efforts has been limited primarily because such programs are typically developed at the Federal level with Federal requirements in mind and frequently neglect the needs of the local project. This serves to limit the value of evaluation insofar as the local project, not seeing data

collection in terms of their own requirements frequently provide inadequate and inappropriate data.

As a solution to these problems, Bokonon Systems has suggested the development of an evaluation model based on the notion of a data classification system. Data describing similar events within the states would be ordered through appropriate analytical packages into a common output necessary for Federal requirements, while concurrently meeting the needs of local and state levels.

To determine the adequacy of this approach, the data presently being collected for use at the Federal level was examined. This data was found to be fragmentary and inappropriate for evaluative purposes. Accordingly, visits to eight states were carried out in an effort to describe the present EPSDT status. The objectives of this effort were to:

- determine what activities are taking place at the state and local levels
- ascertain what data is being recorded and stored
- determine how data stored is being used for program monitoring, evaluation and planning.

Visits to eight states were carried out and data was collected and tabled in the following ways:

State System Information Flow Charts: these charts present for each state the structure of discrete events in the EPSDT cycle and the data flows that are derived from them.

State Data Files Matrix: a listing of EPSDT relevant data files on a state by state basis.

State EPSDT Component Matrix: this matrix describes administrative structures on a state by state basis.

In addition, a narrative description of the findings in all states was prepared and organized into seven descriptive categories that reflect EPSDT concerns. It should be noted that specific state information was submerged in these descriptions to maintain confidentiality of information offered by state personnel. Following are brief summaries of findings by category:

ADMINISTRATION

A wide range of administrative structures were found ranging from distinct programmatic units to add-on responsibilities to pre-existing organizational structures.

In general, EPSDT efforts could be described as a screening program with diagnosis and treatment services offered under normal Title XIX rules (ES-DT) or by a full range program (EPSDT) in which cohesive and organized service delivery was in the process of being implemented.

It is interesting to note that the data files reflect this division. In those states where EPSDT is the primary thrust, a unified data system which may permit tracking and queing of clients was in operation. For those states where early screening was the primary concern, it was typically

found that two or more sets of files existed (i.e., screening, diagnosis and treatment and in some cases additional payment files where fiscal agents were functioning).

With a single exception, (one state line-itemed all EPSDT functions by personnel) it was difficult to ascertain how many administrative personnel were employed for EPSDT. In most cases, EPSDT functions were obtained by adding responsibilities to existing staff.

Objectives of the states visited clustered about two concerns: compliance or refinement. For the former the objectives specified were those necessary to meet basic Federal requirements and assure compliance. These states typically were in early stages of implementation and could be described as "early screening" states. Those states where refinement objectives were articulated had passed beyond concerns of initial inputting of children into screening and were concerned with improving program effectiveness and efficiency.

The objective receiving most mention was "to improve record keeping and statistics". This suggests that efforts are being directed to the problems of monitoring, evaluating and planning as initial struggles in implementing EPSDT are surmounted.

Finally, while states indicated that funds were not a problem, it was

clear that the state budget office was a critical factor in the level of EPSDT functions. In all states the Governor had specified EPSDT as a high priority item and budget offices saw that sufficient funding was available.

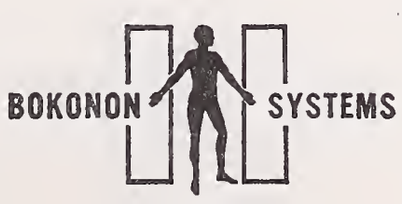
FINANCING

The costs of EPSDT with the exception of screening are difficult to determine. Administrative costs were frequently submerged in other budgets making them impossible to assess. The biggest difficulty was in estimating diagnosis and treatment costs because of the lack of integration of screening, and diagnosis and treatment files.

The costs for screening ranged from $8.00 to $27.00 and for re-screening from $6.50 to $22.50. In no case did a state indicate difficulty in obtaining appropriations for state's EPSDT share. Finally, it should be noted that the use of Medicaid as a first health dollar was rarely the rule. This has increased the difficulty of integrating the other Federally financed health programs servicing children into the EPSDT structure.

PROVIDER AGREEMENTS

States used a number of vendor mixes to provide EPSDT. They ranged from public health clinics to solo providers. In general, selection of service for screening reflected the states past history in health care so one found that states with strong public health programs typically used public health clinics as screening providers. In other states, both screening, and diagnosis and treatment were provided by solo practitioners.



All states indicated difficulty in providing services to rural areas and a general paucity of dental providers. States which required enrollment of vendors in EPSDT typically needed strong recruitment efforts on the part of EPSDT personnel. These programs frequently used financial incentives which took two forms: slightly higher flat rates for screening, and prompt payment of EPSDT generated billings.

While the financial incentives did not seem to have major effects, many states felt that as economic conditions worsened, rapid payments of EPSDT billings which provide vendors with a timely cash flow would lead to increased participation. This, however, may prove to be a problem insofar as increased services to EPSDT eligibles may result in changes in utilization patterns in other populations.

CLIENT ENROLLMENT

While eligible populations are clearly defined in the state Medicaid plans, the problem of locating eligible children in need of EPSDT is complex. In particular, medically needy children are a problem. In addition, targeting specific eligible sub-populations constitutes another problem. Many children are receiving services under various programs (e.g. Title V, public health, Federal categorical programs and private providers). Penetrating this group constitutes a problem insofar as they perceive they are already receiving services.

In addition, expanded efforts toward all children without selectivity appears to result in large numbers of no-shows which increase costs of services and may suggest that the state is doing poorer than it is.

While written mailer and media spots were used in all states most attempted to insure direct caseworker contact in recruitment of eligibles. Support services did not appear to be a problem with a variety of methods being used to provide such services as transportation and day care.

SCREENING

The primary EPSDT thrust for the present is directed toward screening. This is because of recent Federal and legal pressures. Four states were found to use public health clinics for medical screening, while one state relies almost entirely on solo providers. The others (three) use combinations.

One state uses public health dentists and six use private dentists for screening. One state does not dental screen and instead refers all children for treatment. To overcome problems with provider participation in rural areas, one state initiated the use of mobile units for both medical and dental screening.

In terms of the integration with other health programs, a variety of difficulties were found. School programs were typically not used as they are not able to be reimbursed by Title XIX funds, monies they need to improve

their functions to meet EPSDT requirements. While some programs funded by Title V were heavily involved in EPSDT, others were not. Part of the difficulty resulted from more general coverage offered by Title V projects necessitating special data systems to identify EPSDT eligibles. On-going preventive programs such as PKU, vision and hearing screening and immunization were found to have been easily incorporated in EPSDT. Systems were found to be of high quality primarily because they were developed concurrently with and not as add-ons to other programs.

Aside from utilization review procedures, the evaluation of screening was non-existent. This reflects two problems: the state of the art in determining medical service quality, and the lack of time and personnel available to carry out such efforts.

DIAGNOSIS AND TREATMENT

The intent of EPSDT legislation is manifested when screening identifies health problems which are in turn confirmed through diagnosis and subsequently receive treatment. The impact of the program requires that one shows that early detection of morbidity (for which there is treatment) and treatment lead to decreases in long term debilitating illnesses.

While EPSDT has not been in existance long enough to examine its impact the question of whether or not one can determine if the legislative mandate is being met is more difficult than would be expected.

The primary problem lies in the fact that most states have concentrated on in-putting children into screening with the expectation that normal Title XIX procedures could provide diagnosis and treatment. Whether this was occurring is difficult to determine since most states visited had separate diagnosis and treatment data files making it difficult to determine who was receiving EPSDT. The problem was further compounded by children who received treatment during screening for which no bill or report was prepared. The present approach is to attempt to match positive screening profiles with diagnosis and treatment payment claims. This method is filled with pitfalls: some public and private providers are far behind in billings, and some billing forms were found not to be specific enought to discriminate episodic encounters from a referral.

The quality of diagnosis and treatment data files varies widely, the most prevalent problem being continuity between screening diagnosis and treatment. However, a far more serious problem is that resulting from the controversy surrounding the use of procedure codes. One state reported that despite having Medical Society approval for a code they used, over 70% of treatment billings were listed outside the codes as "other".

Evaluation typically consisted of utilization review procedures although one state maintained a mobile dental van which checked quality as well as fraud by re-examining children for whom bills have been submitted. No

state appeared to have long range focus on the use of diagnosis and treatment for evaluation nor was any state found to be considering the relationship of treatment to outcome as a possible measure of the impact of EPSDT.

CASE MANAGEMENT

It appeared from our visits that case management was the most critical determinant of the level of success of EPSDT efforts. Strong and aggressive case management seems to be able to overcome structural limitations of the program. The major problem caseworkers have is the lack of organized file systems which would permit them to track clients' status without requiring considerable effort on their part to assure continuity through screening, diagnosis and treatment.

In general it can be concluded that the states were moving towards full implementation of EPSDT and in doing so had developed sophisticated data systems. The biggest problem at present is that immediate concerns have left very little time for consideration of uses of the data for monitoring, evaluation and planning.

It is expected that this effort will serve as in-put for the next stage of the development of the evaluation model. This next stage, which awaits specification of Federal evaluation requirements, will see the use of the information collected at the state organized into a data classification system. It is intended that the model will demonstrate its usefulness at the local level as well as meeting state and Federal evaluation needs.

2.0 BACKGROUND

Federal health programs have evolved along two basic strategies: Categorical programs which stress service delivery exemplified by programs mandated under Title V of the Social Security Act; and financing programs such as Medicare (Title XVIII) and Medicaid (Title XIX). The goal of both approaches is the same, namely to provide the poor and medically needy with access to health care and thereby improve the health status of these populations.

The former (e.g., Title V programs) provides direct services through categorical delivery mechanisms, which increase the availability of health services to specific target populations. The latter programs (e.g., Title XVIII and XIX) function to eliminate the financial barriers which prevent the poor from utilizing available medical services.

EPSDT, mandated under the 1967 Amendments to Title XIX, is unique insofar as it is a financing program whose legislation specifies the provision of direct services to target populations. The ambiguity resultant from this mix is further compounded by the state option inherent in Title XIX which permits the states to determine the extent of their participation in these financing programs. The result is that EPSDT plans like State Medicaid Plans, which they are part of, are packages of benefits and restrictions tailored to the structure, philosophy and objectives of individual states. These range from minimally mandated

services necessary for legislative compliance to the initiation of a program of comprehensive health care to children.

Implementation of EPSDT has been slow and uneven. The difficulty is a function of numerous problems. Despite the fact that legislation was enabled in 1967, it was not until 1972 that the Federal government issued regulations and guidelines which were followed by a strong Federal thrust for program implementation. Concurrently, many states were faced with legal suits resulting in judgements requiring "full" and "rapid" implementation.

This late start under the dual pressures of Federal compliance and legal mandates appears to have resulted in the bulk of state efforts being directed in a hurry-up fashion to locating and funneling children through screening to the detriment of an organized, comprehensive EPSDT program. This seems to be born out by the nature of available information from which to describe various state efforts. What information is available appears fragmentary and inconsistent serving to frustrate planning, policy making and coordination among the numerous agencies involved in EPSDT at all levels of responsibility and operation (i.e., local, state, Federal).

The problem of understanding the program on the basis of available information is made more complex by the nature of Title XIX legislation. Since states are allowed program options and accordingly may provide different

ranges of services to different target populations, it may be expected that the information systems by which states operate would be different from state to state.

The wide range of data systems constitutes a difficult problem for planning and policy making, since it makes comparison between programs difficult if not impossible. Clearly, the present state of EPSDT contraindicates the traditional evaluation methodology used at the Federal level which requires uniform data specifications and collection.

Parenthetically, it should be noted that even in programs where Federal regulations require the collection of uniform data, evaluation results have typically been poor and inappropriate. The reasons for this are many. Most important, however, is the recognition that uniformly imposed information and evaluation systems typically neglect the needs of the local implementer who in the final analysis is the responsible agent for data collection. Not understanding data collection requirements in terms of their own self interest, limited attention is directed to such efforts. The result is fragmentary, inaccurate and unreliable data leading to weak evaluation.

In response to these problems, Bokonon Systems has proposed a solution. Given the fact that states have initiated EPSDT within different organizational structures and through different interpretations, a simple

fact remains: regardless of the nature of EPSDT implementation early and periodic screening, diagnosis and treatment must be delivered to the eligible population at a minimal level in each state. Accordingly, there should be substantive commonality among the states with respect to what they are doing which probably offsets the weighty differences which exist.

This position gave rise to the notion of the development of a data classification system which could be used to evaluate a wide range of EPSDT efforts. By "classification system" we mean the ordering of data describing similar events collected at different states into categories by functional activities. Such a system would be based on the determination of data various states are presently collecting and the organization of this data through analyses packages into a common output necessary for Federal requirements.

To determine the adequacy of this approach, two initial efforts were proposed:

1. Assessment of data presently collected at the Federal level.
2. Site visits to estimate what exists within the states.

In a preliminary report *, data from MSA files were examined and reorganized to determine what was known about a limited number of states.

Subsequently, eight states were selected for site visits. These states in the order visited were:

Illinois

South Carolina

Florida

Washington

Texas

Louisiana (New Orleans) **

Oklahoma

New York

The data collected during these site visits were analyzed and serve as the basis for this report.

3.0 DATA COLLECTION PROCEDURES

Eight states were visited to determine present status of EPSDT information. In particular, state and local personnel were interviewed to:

---

* PRELIMINARY ANALYSIS OF EPSDT STATUS, Review of Monitoring Reports - Site Selection Recommendations, Contract #SRS 74-63; Bokonon Systems; September 1974.

** The New Orleans Health Department has functioned independently of the State Public Health Department to date. It also has developed under federal grant an independent information system. Accordingly it is treated separately in this report.

- determine what activities are taking place at state and local levels
- ascertain what data is being recorded and stored
- determine how data stored is being used for purposes of program monitoring and evaluation.

At each state, relevant personnel contacted were interveiwed utilizing an informal questionnaire.

3.1 QUESTIONNAIRES

Review of the MSA data suggested concerns under which program elements could be categorized. These were:

Administration:	Organization of EPSDT bureaucracy Policy, planning and objectives Information systems
Financing:	Costs of EPSDT Availabilities by category of expenditure Medicaid regarding other health dollars Projected direct costs
Provider Agreements:	Range of enrollment procedures Screening and Diagnosis and Treatment providers Fee schedules
Enrollment:	Means of targeting eligible subpopulations Outreach methods and scheduling No shows and periodicity Determining penetration rate
Screening:	Types of providers Interaction with other programs Types of screening packages Records Referrals

Diagnosis & Treatment:	Types of providers Interaction with other programs Linkage to screening outcomes Follow-up False negatives, false positives Records
Case Management:	Responsible agencies Periodicity Diagnosis and treatment follow-up Records

To facilitate the interviews, informal questionnaires were prepared in which questions relating to EPSDT were organized according to the preceeding categories. A separate although similar questionnaire was prepared for state and local project interviews. These questionnaires appear in Appendix A.

The questionnaires were constructed in such a way as to serve as reference questions when available data or oral review of present EPSDT efforts by interviewees was insufficient. During the course of the interviews the order of questions was changed to reflect the concerns of particular states and/or local projects.

3.2 FIELD VISITS

A site visit schedule was prepared and contact with Regional Offices was initiated. Some changes in scheduling were required insofar as the time planned for our visits coincided with the State Compliance Review.

Before visiting a state, the team assembled in the Regional Office and reviewed the interview schedule to determine which question areas it would be most beneficial to focus upon. At the same time, Regional Staff were queried in an effort to assess their information needs for evaluation purposes.

The team consisted of a health specialist and two system specialists who after an initial review of state EPSDT efforts met with state personnel in their respective specialities. This was done to minimize the amount of time at each state and to insure that our presence did not cause major disruptions in state operations.

It is important to note that the wide range of state personnel interviewed share common attitudes with respect to EPSDT, namely, a strong dedication to ensuring the success of EPSDT. In addition, we were gratified by the response of personnel at states, who, despite short notice were able to put together appropriate documentation and to provide us with detailed descriptions of their programs, necessary to the success of this effort.

One final note, while we expected to spend considerable time at local sites, we discovered a remarkable degree of centralization within states and for the most part it was not required that we actually go to local sites. In cases where it was important, local personnel were made

available at the State Offices. However, in particular, site visits were made to New Orleans and New York City to meet with the local project director and review program operations.

4.0 SITE STATUS

The site visit effort was initiated to determine the extent of state information and evaluation efforts and to assess whether or not the information systems in place could support the concept of using a data classification system to meet the evaluation needs at local, state, and Federal levels. In particular, the objectives of the state site visits were:

- To describe in place EPSDT efforts
- To determine what data are being recorded
- To determine what uses are being made of this data

During the course of the site visitations, state EPSDT efforts were reviewed and documentation to support information systems and uses of information were requested and received. The information gathered at the states was then organized so that we could determine the extent of information systems available for EPSDT. The data were then detailed in a systems flow chart for each state.

Subsequently, all information collected was organized into seven aforementioned categories which describe program operations*. Data from states

*These categories are detailed in PRELIMINARY ANALYSIS OF EPSDT STATUS.

was used to describe various phenomena within each category. In addition, the barriers to effective functioning vis-a-vis these categories are also discussed.

The following sections present state system flow charts and descriptions of EPSDT functions within the eight categories.

4.1 STATE SYSTEM INFORMATION FLOW CHARTS

Data gathered at the states which describe the information systems were reviewed and reorganized to integrate two critical factors of EPSDT functions. These are: the structure of discreet events in the EPSDT cycle; and the data flows that derive from the events.

Six states and one local project have been charted. Two states, Texas and New York, do not appear. In the case of Texas we are awaiting documentation to insure completeness and accuracy.*

In the case of New York State, no chart has been prepared since the state

---

* Our visit to Texas coincided with a trip out of town by the State Medicaid Director whose approval is required before any documentation may leave the State Office. State personnel were extremely helpful and much information was gathered including identification of specific documentation required for our report. A request for this documentation has since been forwarded to the State Medicaid Director and we are presently awaiting a response.

functions in a supervisory role with Medicaid and EPSDT administration being a local option. What this means is that New York State really consists of 58 separate jurisdictions each of which files its own plan. Parenthetically, it should be noted that the wide range of efforts within New York State most probably represents a microcosmic view of EPSDT efforts across the nation.

In addition, it should be noted that New York State is presently attempting to implement a Child Health Assurance Program (CHAP). This program further extends the parallel between the Federal Government/states and New York/counties as CHAP establishes guidelines and mandates county plans and objectives. In any event, the complexity of New York State coupled with the present state of flux of the program makes charting their efforts of no present value.

Each flow chart is preceded by a brief narrative description of the state's EPSDT structure. The organizational structure and inter-relationship between various state agencies are then pictured in a graphic presentation. Subsequently, information describing EPSDT functions appear. Each function is described in terms of responsibility and the file generated by the requirement procedures.

Following is a brief definition of the EPSDT functions:

- EPSDT INITIATION, PLANNING AND POLICY

Describes general divisions of responsibility between state agencies and subcontractors.

- ELIGIBILITY DETERMINATION AND IDENTIFICATION

  Describes responsibility and method of eligibility determination, assignment of identification number and eligibility files.

- PROVIDER RECRUITMENT

  Describes responsibility and arrangements for provider recruitment for screening, diagnosis and treatment and dental services. Also, provides identification code, files and formal agreements or contracts.

- SCREENING, NOTIFICATION AND SCHEDULING

  Identifies responsibility for notifying and scheduling for screening. Includes methods and files.

- NO-SHOWS AND PERIODICITY

  Specifies responsibility for checking no-shows and re-scheduling. Identifies files and methods.

- SUPPORT SERVICES

  Identifies types and responsibility for social services delivery such as transportation and day care.

- FAMILY CASE HISTORY

  Describes collection and storage of case history, method for updating and identifies who can access information.

- SCREENING REIMBURSEMENT

  Specifies who bills whom, fee schedule, storage and eligibility checks.

- SCREENING EVALUATION AND UTILIZATION REVIEW

  Who is responsible for evaluation and utilization review and how is it performed.

FLORIDA

EPSDT RESPONSIBILITY

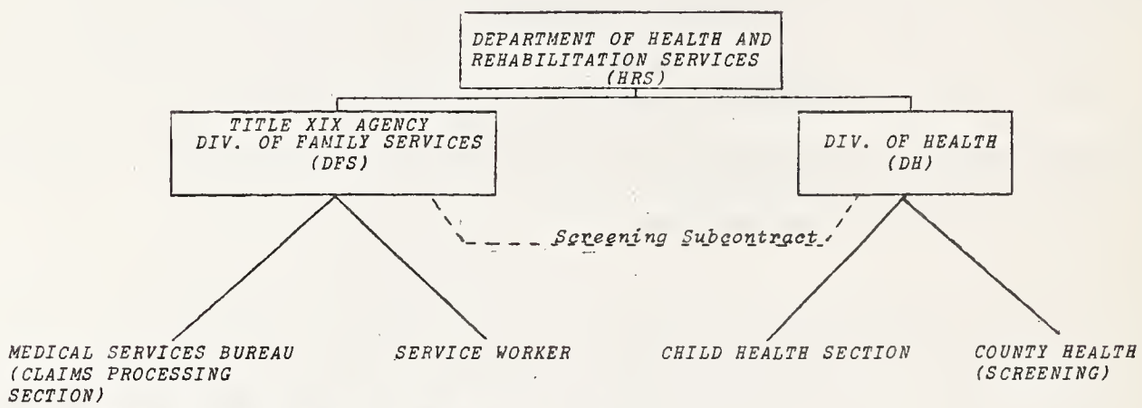
The Department of Health and Rehabilitation Services, the social services umbrella agency for Florida has allocated EPSDT responsibilities between the Division of Family Services (the Title XIX agency) and the Division of Health.

The Health Office screens through county health departments. Per capita flat rate reimbursement is under authority of the Bureau of Medical Services/DFS. The Bureau is responsible for the overall surveillance and administration of EPSDT.

EPSDT INFORMATION FLOW

FLORIDA

ORGANIZATION



INFORMATION FLOW

STRUCTURE

FILE SETS

EPSDT INITIATION, PLANNING AND POLICY

BY AGREEMENT BETWEEN DFS AND DH SCREENINGS WILL BE ACCOMPLISHED BY COUNTY HEALTH DEPARTMENTS.

THE BUREAU OF MEDICAL SERVICES IS RESPONSIBLE FOR THE OVERALL SURVEILLANCE AND ADMINISTRATION OF EPSDT.

AT PRESENT THE DEPARTMENT OF HRS AND THE DEPARTMENT OF EDUCATION ARE WORKING TOWARDS A COMPREHENSIVE SCHOOL HEALTH SERVICE PLAN.

EVERY SIX MONTHS DFS AND DH RENEGOTIATE SCREENING REIMBURSEMENT RATE. (AT PRESENT $10.00 - 1.50 TO STATE HEALTH DEPARTMENT AND $8.50 TO COUNTY HEALTH DEPARTMENT).

ELIGIBILITY DETERMINATION AND ID NUMBER

ALL MEDICAID AFDC, FOSTER CARE AND SSI UNDER AGE TWENTY-ONE.

RESPONSIBILITY OF DFS.

EVERY SIX MONTHS DFS PREPARES AN UPDATED ELIGIBILITY TAPE. MONTHLY THEY PRINT-OUT AN ELIGIBILITY LIST BY COUNTIES. ALSO SEND EPSDT INFORMATION EVERY SIX MONTHS.

PROVIDER RECRUITMENT

SCREENING: COUNTY HEALTH DEPARTMENT

DIAGNOSIS AND TREATMENT: RESPONSIBILITY OF MSB TO PROVIDE COUNTY HEALTH DEPARTMENTS WITH A LIST OF MEDICAID PROVIDERS. DIAGNOSIS AND TREATMENT VENDORS MUST APPLY TO STATE BOARD OF HEALTH.

STRUCTURE	FILE SETS
NOTIFICATION AND SCHEDULING FOR SCREENING	
EITHER DFS SERVICE WORKER OR THE COUNTY DEPARTMENT OF HEALTH CAN SET UP AN APPOINTMENT BY USING THE MONTHLY ELIGIBILITY REPORT ISSUED BY DFS.	THE DFS ELIGIBILITY TAPE IS USED BY MEDICAL SERVICE BUREAU TO SET UP: 1) INDIVIDUAL SERVICE FILE. 2) TO CHECK IF TRANSACTION NUMBER CAN BE ISSUED.
NO SHOWS AND PERIODICITY	
RESPONSIBILITY OF DFS SERVICE WORKER OR COUNTY HEALTH DEPARTMENT TO NOTIFY SERVICE WORKER OF A NO SHOW.	
SUPPORTIVE SERVICES	
PROVIDING TRANSPORTATION OR DAY CARE IS RESPONSIBILITY OF DFS SERVICE WORKER. - OR - DH WILL SET UP A SCREENING TEAM TO GO TO RURAL AREAS.	
FAMILY CASE HISTORY	
DFS OBTAINS INFORMATION AT ELIGIBILITY DETERMINATION.	HARDCOPY RETAINED BY DFS AT STATE LEVEL.
REIMBURSEMENTS FOR SCREENING	
1) NO SET SCREENING FORM FOR RECORDING THE EXAMINATION. 2) MONTHLY MEDICAID SCREENING REPORT FORM FILLED OUT BY HEALTH CLINIC. (JUST TOTALS). 3) AFTER A SCREENING THE PROVIDER OBTAINS FROM DFS A TRANSACTION NUMBER FOR EACH CHILD. WITHIN A WEEK DFS SENDS A SCREENING BILLING DOCUMENT WICH IS FILLED IN BY THE HEALTH CLINICS AND SENT TO MSB.	1) HARDCOPY KEPT BY HEALTH CLINIC. 2) HARDCOPY KEPT BY DFS. 3) MSB UPDATES TRANSACTION NUMBER TAPE AND GENERATES A SCREENING BILLING DOCUMENT. THE INDIVIDUAL SERVICE FILE IS UPDATED WITH SCREENING PERFORMED AND PROCEDURE CODES FOR REFERRALS.
SCREENING EVALUATION AND UR	
CHILD HEALTH INVESTIGATES BY SITE VISITS AND QUESTIONNAIRES.	
MEDICAL CASE HISTORY	
IF PARENT IS PRESENT AT SCREENING HISTORY INFORMATION SHOULD BE REQUESTED BY COUNTY HEALTH DEPARTMENT.	COUNTY HEALTH CLINICS MAY KEEP HARDCOPY OF THEIR SCREENING FORM. MSB KEEPS HARDCOPY OF SCREENING BILLING DOCUMENT AND DIAGNOSIS AND TREATMENT BILLS. DOCTOR OR DENTIST SHOULD KEEP CASE HISTORY.
REFERRAL FOR DIAGNOSIS AND TREATMENT	
APPOINTMENTS MADE EITHER BY COUNTY HEALTH DEPARTMENT OR DFS WORKER. THEY BOTH HAVE ACCESS TO TERMINAL WHICH CAN DISPLAY INDIVIDUAL SERVICE FILE.	
REIMBURSEMENT FOR DIAGNOSIS AND TREATMENT	
DOCTORS AND DENTISTS WHO HAVE APPLIED FILL OUT REQUEST FOR PAYMENT FORMS. ALSO DOCTOR OR DENTIST CAN CHECK IF SUFFICIENT AMOUNT FOR EACH CHILD'S TREATMENT REMAINS OR SPECIAL REQUEST IS NEEDED.	MSB FIRST CHECKS THAT A TRANSACTION NUMBER WAS ISSUED, AND THAT PROCEDURE AND AMOUNT IS CORRECT. DOCTOR MUST SUBMIT BILL WITHIN NINETY DAYS OF TREATMENT AND MUST OBTAIN A TRANSACTION NUMBER WITHIN SIXTY DAYS OF TREATMENT.
DIAGNOSIS AND TREATMENT EVALUATION AND UR	
MSB PERFORMS UR PRIOR TO PAYMENT. MSB CAN SEND FIELD REPRESENTATIVES TO A PRIVATE OFFICE TO COMPARE CLIENT MEDICAL RECORDS WITH PROCEDURES CLAIMED ON SUBMITTED BILLS.	MSB MANUALLY CHECKS EACH BILL FOR TRANSACTION NUMBER REQUEST, REIMBURSEMENT AND LIMITS ON PROCEDURES, AND HIGH VOLUME VENDORS.

ILLINOIS

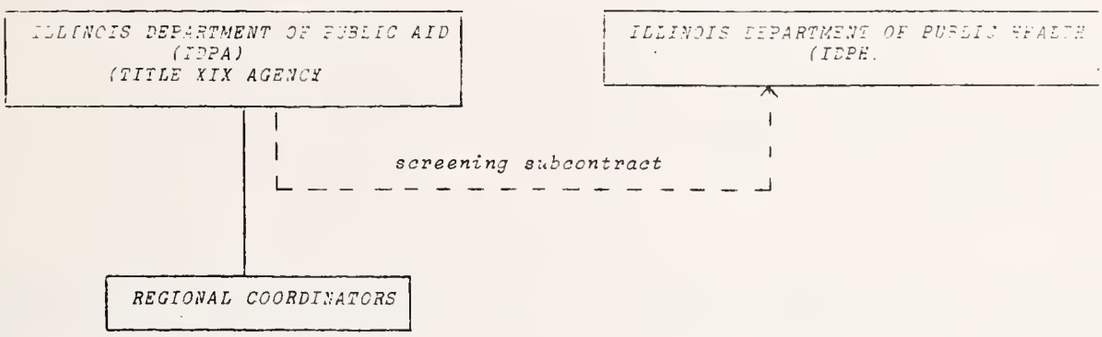
EPSDT RESPONSIBILITY

A formal contract between the Department of Public Aid and the Department of Public Health divides administrative and operational tasks. Public Aid is the Title XIX agency with administrative and fiscal responsibility. Public Health monitors screening, recruits screening providers, and evaluates screening.

EPSDT INFORMATION FLOW

ILLINOIS

ORGANIZATION



INFORMATION FLOW

STRUCTURE	FILE SETS
EPSDT INITIATION, PLANNING AND POLICY	
IDPA IS THE TITLE XIX AGENCY WITH ADMINISTRATIVE AND FISCAL RESPONSIBILITIES OF EPSDT.	
IDPA HAS SUBCONTRACT WITH IDPH FOR EARLY SCREENING AND PERIODICITY: - STATE PLAN (ES & P): IDPA AND IDPH - MONITORING (ES & P): IDPH - EVALUATION (ES & P): IDPH	
TOGETHER IDPH AND IDPA DECIDE ON PROCEDURES AND REIMBURSEMENT.	QUARTERLY ESTIMATES OF ADMINISTRATION AND PROVIDER SCREENING COSTS ARE PREPAID TO IDPH BY IDPA. IDPH COMPUTES THIS ESTIMATE FROM THEIR BILLING MASTER.
ELIGIBILITY DETERMINATION AND ID NUMBER	
ELIGIBLES ARE CATEGORICALLY AND MEDICALLY NEEDY UNDER TWENTY-ONE.	
IDPA REDETERMINES ELIGIBILITY EVERY FOUR MONTHS.	UPDATES ELIGIBILITY FILE ON IDPA COMPUTER. IDPA ISSUES NEW FAMILY MEDICAID ID CARD MONTHLY.
PROVIDER RECRUITMENT	
SCREENING: IDPH ASSIGNS SCREENING VENDOR NUMBER TO COUNTY HEALTH CLINICS IF THEY QUALIFY. SCREENING MAY ALSO BE DONE BY LICENSED DOCTOR OR DENTIST WHO REQUESTS SCREENING VENDOR NUMBER.	VENDORS FOR SCREENING ARE A VARIABLE ON IDPH BILLING MASTER. THEY ARE GIVEN A SPECIAL VENDOR NUMBER - NOT THE SAME AS MEDICAID VENDOR NUMBER.

STRUCTURE	FILE SETS
DIAGNOSIS AND TREATMENT: ANY ILLINOIS CLINIC, DOCTOR OR DENTIST ELIGIBLE TO PROVIDE MEDICAID SERVICES. OUT OF STATE PROVIDERS MUST APPLY.	IDPA MEDICAID FILE.
REGIONAL COORDINATORS ENLIST NEW PROVIDERS.	MAINTAIN A HARDCOPY LIST AND UPDATE IDPH BILLING MASTER.
NOTIFICATION AND SCHEDULING FOR SCREENING	
SOCIAL SERVICE WORKERS MAKE A HOME VISIT AND INFORM RECIPIENTS WHERE APPOINTMENTS CAN BE MADE (AFDC ELIGIBLES HAVE FIRST PRIORITY).	IDPA RUNS PROGRAM USING ELIGIBILITY FILE AND SENDS LIST OF NEW ELIGIBLES TO SOCIAL SERVICE WORKERS.
NO SHOWS AND PERIODICITY	
SOCIAL SERVICE WORKERS RESPONSIBILITY.	
SUPPORTIVE SERVICES	
CONTACT: AT HOME VISIT BY SOCIAL SERVICE WORKER.	
TRANSPORTATION: SOCIAL SERVICE.	
FAMILY CASE HISTORY	
INFORMATION CASE HISTORY FILLED OUT AT HOME VISIT BY SOCIAL SERVICE WORKER.	SOCIAL SERVICE WORKER FILES HARDCOPY. CASE IDENTIFICATION TRANSFERRED TO IDPA ELIGIBILITY FILE.
REIMBURSEMENT FOR SCREENING	
SCREENING FORMS ARE SENT TO IDPH 1) MEDICAL SCREENING FORM 2) DENTAL SCREENING FORM 3) VISION/HEARING SCREENING FORM.	ALL ITEMS ARE ADDED TO CHILD SCREENING FILE ON IDPH COMPUTER. COST, PROCEDURE, DATE AND VENDOR NUMBER ARE ADDED TO IDPH BILLING MASTER. IDPH FIRST CHECKS MANUALLY AND MAKES PERSONAL CALLS IF ANY ERRORS ARE FOUND ON FORMS. IDPH THEN REIMBURSES VENDOR AT CUSTOMARY FEE OR MAXIMUM AMOUNT ALLOWED. FROM CHILD SCREENING FILE THE MEDICAL FOLLOW-UP REPORT IS GENERATED AND SENT TO SERVICE WORKERS. HARDCOPY IS ALSO KEPT BY IDPH FOR OPM REPORTS.
SCREENING EVALUATION AND UR	
RESPONSIBILITY OF IDPH. CLINICS MUST HAVE WRITTEN LETTERS FROM DOCTORS AND DENTISTS SAYING THEY WILL TAKE REFERRALS.	
MEDICAL CASE HISTORY	
SCREENING FILE IS SEPARATE FROM DIAGNOSIS AND TREATMENT FILE.	IDPH HAS CHILD SCREENING FILE. - HISTORY - TAKE INFORMATION OFF OF IDPA ELIGIBILITY FILE - MEDICAL RECORD - DENTAL RECORD - VISION/HEARING RECORD ADDITIONAL SCREENINGS ARE ADDITIONAL RECORDS. IDPA KEEPS SEPARATE MEDICAID TREATMENT FILE.
REFERRAL FOR DIAGNOSIS AND TREATMENT	
CAN BE DONE BY DOCTOR OR AGENCY PERFORMING SCREENING. SOCIAL SERVICE WORKER CAN CHECK ON THIS BY ASKING FAMILY AND FILLING OUT MEDICAL FOLLOW-UP REPORT.	A HARDCOPY OF MEDICAL FOLLOW-UP REPORT IS KEPT BY IDPA AND IDPH AFTER SERVICE WORKER HAS CIRCLED ACTION TAKEN.

STRUCTURE	FILE SETS
REIMBURSEMENT FOR DIAGNOSIS AND TREATMENT	
FORMS ARE SENT TO IDPA. 1) PHYSICIAN'S STATEMENT OF SERVICES RENDERED. 2) DENTIST STATEMENT. 3) STATEMENT OF OPTICAL GOODS AND SERVICES.	THESE FORMS ARE FIRST CHECKED MANUALLY BY IDPA THEN USED TO CREATE NEW MEDICAID TREATMENT FILE TO BE USED AS UP-DATE FOR OLD FILE. NEW MEDICAID TREATMENT FILE IS CHECKED AGAINST: - ELIGIBILITY FILE - PROCEDURE AND REIMBURSEMENT FILE - VENDOR FILE. IT IS THEN USED TO UPDATE PAYMENT HISTORY FILE AND REIMBURSE VENDORS.
DIAGNOSIS AND TREATMENT EVALUATION AND UR	
RESPONSIBILITY OF IDPA. DENTAL BILLS ARE REVIEWED BY ILLINOIS DENTAL SERVICE.	

LOUISIANA

EPSDT RESPONSIBILITY

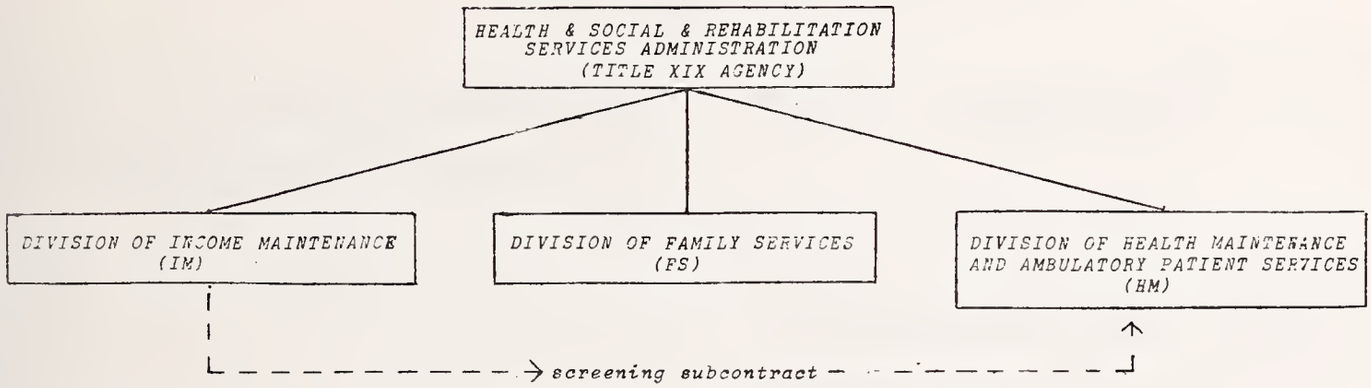
A recently formed social services umbrella agency, the Health and Social and Rehabilitation Services Administration, is the Title XIX agency in Louisiana.

The Divisions of Income Maintenance and Health Maintenance and Ambulatory Patient Services function under formal agreements. IM retains administrative responsibility. HM performs screening through parish health departments, billing the Division of Family Services for diagnosis and treatment, and IM for screening. The Health Departments bill IM for treatments that occurred as an outcome of a screening referral.

EPSDT INFORMATION FLOW

LOUISIANA

ORGANIZATION



INFORMATION FLOW

STRUCTURE	FILE SETS
EPSDT INITIATION, PLANNING AND POLICY	
IM SUBCONTRACTS TO HM TO PROVIDE EARLY AND PERIODIC SCREENING AND DIAGNOSTIC SERVICES. HM BILLS IM FOR THE COSTS OF THESE SERVICES AND FURNISHES FISCAL AND STATISTICAL INFORMATION REGARDING THESE COSTS.	INCOME MAINTENANCE REIMBURSES ALL SCREENING COSTS AND SOME DIAGNOSIS AND TREATMENT BILLS.
FS IS BILLING BY PROVIDERS OF DIAGNOSIS AND TREATMENT EXCEPT FOR THE CASE WHEN A CLIENT WAS DIRECTLY REFERRED BY HEALTH DEPARTMENT AND SPECIAL ARRANGEMENTS WERE MADE.	FAMILY SERVICES REIMBURSES ALL OTHER DIAGNOSIS AND TREATMENT BILLS.
SCREENING IS ACCOMPLISHED IN TWO VISITS. COMPLETION OF A MEDICAL HISTORY FORM, MEASUREMENTS, AND LAB TESTING ARE DONE DURING THE INITIAL VISIT. AN APPOINTMENT IS SCHEDULED FOR A RETURN VISIT WITHIN TWO WEEKS (AFTER LAB TESTS) FOR A PHYSICIAN'S EXAMINATION.	SCREENING FORM RECORDS EXACT TIME SPENT ON A CLIENT BY EACH CATEGORY OF HEALTH DEPARTMENT EMPLOYEE. THIS ENABLES THEM TO COMPUTE EXACT SCREENING COSTS TO NEGOTIATE RATES.
ELIGIBILITY DETERMINATION AND ID NUMBER	
RESPONSIBILITY OF FAMILY SERVICES.	
INCLUDES AFDC, FC AND SSI UNDER TWENTY-ONE.	FAMILY SERVICES SUBMITS AN UPDATED QUARTERLY LIST OF ELIGIBLES TO HM WHO IN TURN SENDS LIST TO EACH PARISH HEALTH DEPARTMENT.
A CLIENT'S ID NUMBER IS THEIR SOCIAL SECURITY OR PARENT'S SOCIAL SECURITY NUMBER PLUS A TWO DIGIT CODE IDENTIFYING CHILD'S BIRTH STATUS.	FAMILY SERVICES PRODUCES THREE ID CARDS FOR EACH ELIGIBLE CHILD - ONE FOR CENTRAL CARD FILE KEPT BY HM - ONE FOR FS - ONE TO PARISH HEALTH DEPARTMENT.

STRUCTURE	FILE SETS
PROVIDER RECRUITMENT	
SCREENING: HEALTH MAINTENANCE RESPONSIBILITY FOR SCREENING AND REFERRAL.	
DIAGNOSIS AND TREATMENT: USE TITLE V, STATE HEALTH PROGRAMS (TB, VD, HANDICAPPED CHILDREN AND DENTAL HEALTH). STATE INSTITUTIONAL CARE PROGRAM AND PRIVATE PHYSICIANS LICENSED BY STATE MEDICAL ASSOCIATION.	- FS PROVIDER FILE - IM PROVIDES A LIST OF DENTISTS WILLING TO PARTICIPATE IN EACH PARISH.
NOTIFICATION AND SCHEDULING FOR SCREENING	
INITIAL NOTIFICATION TO ALL ELIGIBLES AT INTAKE AND RECERTIFICATION IS FOLLOWED BY PERSONAL CONTACT BY A SOCIAL WORKER. AT THIS TIME AN APPOINTMENT CAN BE MADE FOR INITIAL SCREENING AND THE SOCIAL SERVICE CERTIFICATION AND DISPOSITION FORM CAN BE FILLED OUT FOR EACH MEMBER OF THE FAMILY.	ONE COPY OF FORM IS KEPT BY SOCIAL WORKER AND ONE COPY IS SENT TO FS.
NO SHOWS AND PERIODICITY	
PARISH HEALTH DEPARTMENT CAN INFORM PARISH SOCIAL WORKER OR THEY CAN CONTACT THE CLIENT THEMSELVES.	THE PARISH HEALTH DEPARTMENT IS AWARE OF NO SHOWS SINCE SCREENING APPOINTMENTS ARE MADE. THE PARISH HEALTH DEPARTMENT KEEPS INDIVIDUAL MEDICAL FOLDERS WHICH CAN BE CHECKED FOR PERIODIC SCREENING.
SUPPORTIVE SERVICES	
SOCIAL SERVICE WORKER HAS THE RESPONSIBILITY TO MAKE NECESSARY ARRANGEMENTS TO ASSURE THAT CHILDREN CAN GET TO SCREENING SITE. AFTER FIRST PART OF SCREENING, PARISH HEALTH DEPARTMENT IS RESPONSIBLE FOR MAKING ARRANGEMENTS WITH THE MOTHER AND CHILD TO GET BACK TO THE CLINIC. SOCIAL SERVICE WORKERS CAN BE CALLED UPON TO ASSIST IN PROVIDING THESE SERVICES.	
FAMILY CASE HISTORY	
SOCIAL SERVICES CERTIFICATION AND DISPOSITION FORM CONTAINS FAMILY HISTORY.	PART OF THIS FORM IS MACHINE READABLE AND CREATES AN INDIVIDUAL RECORD ON FS SOCIAL SERVICE CASE FILE.
CLIENT SERVICE PROFILE AND COPY OF SCREENING FORM (SERVICES RENDERED TO CHILDREN ELIGIBLE FOR EPSDT).	KEPT AS HARDCOPY BY PARISH SOCIAL WORKER.
REIMBURSEMENT FOR SCREENING	
AFTER SECOND PART OF SCREENING IS COMPLETED THE SERVICES RENDERED TO CHILDREN ELIGIBLE FOR EPSDT IS SUBMITTED TO INCOME MAINTENANCE FOR REIMBURSEMENT.	INCOME MAINTENANCE FIRST CHECKS SCREENING FORM AND REIMBURSES BASED ON VALUE CODES ASSOCIATED WITH EPSDT PROGRAM. THIS FORM IS MICROFILMED AND STORED ON COMPUTER BY INCOME MAINTENANCE AND THEN SENT BACK TO PARISH HEALTH DEPARTMENT.
NO DENTAL SCREENING - SEE DIAGNOSIS AND TREATMENT.	
SCREENING EVALUATION AND UR	
INCOME MAINTENANCE MAY AUDIT HEALTH MAINTENANCE RECORDS. HEALTH MAINTENANCE IS RESPONSIBLE FOR EVALUATING THE PARISH HEALTH CLINICS.	
MEDICAL CASE HISTORY	
THE MEDICAL CASE HISTORY FOLDER MAY CONSIST OF: - HISTORY TAKEN AT SCREENING - SCREENING FORMS - REFERRAL FORMS - TREATMENT FORMS BILLED TO HEALTH DEPARTMENT.	HARDCOPY KEPT BY PARISH HEALTH CLINIC.

STRUCTURE	FILE SETS
THE PARISH SOCIAL WORKER ALSO RECEIVE A COPY OF SCREENING FORM TO BE KEPT IN CASE FILE.	
REIMBURSEMENT FOR DIAGNOSIS AND TREATMENT	
DENTISTS MAY PROVIDE SPECIFIC SERVICES AFTER AGE TWO WITHOUT PRIOR AUTHORIZATION. ALL DENTAL BILLS ARE SUBMITTED TO FAMILY SERVICES. HEALTH DEPARTMENTS ARE REIMBURSED ON ACTUAL COST BASIS FOR TREATMENT.	DFS CHECKS BILLS MANUALLY AND REIMBURSES USUAL CUSTOMARY FEE OR FEE SCHEDULE (WHICHEVER IS LESS). THIS IS STORED ON PHYSICIAN CLAIM FILE.
PRIVATE PROVIDERS WHO ACCEPT REFERRALS FROM SCREENING CAN BILL THE HEALTH DEPARTMENT OR DFS UNDER REGULAR TITLE XIX.	TREATMENT BILLS SUBMITTED BY IM TO HEALTH ARE THEN SUBMITTED TO IM. THIS ALLOWS TREATMENT TO BE TIED TO SCREENING OUTCOME
DIAGNOSIS AND TREATMENT EVALUATION AND UR	
DFS HAS COMMITTEE TO REVIEW BILLS FOR FRAUD.	MANUAL CHECK FOR UNUSUAL BILLS. ALSO DFS CAN USE THEIR PHYSICIANS CLAIMS FILE TO IDENTIFY HIGH VOLUME VENDORS, UNUSUAL PROCEDURE INCIDENCES, ETC.

NEW ORLEANS

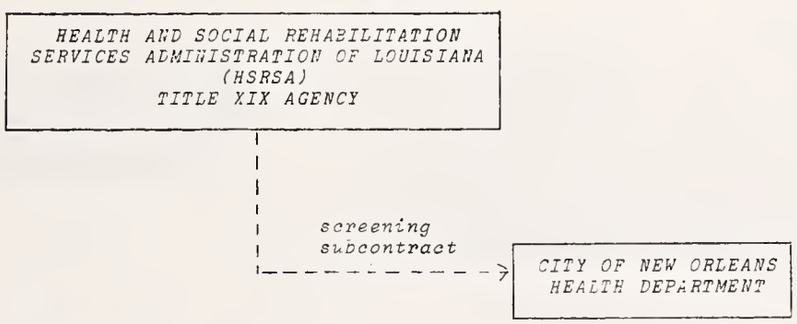
EPSDT RESPONSIBILITY

The City of New Orleans Health Department is contracted by the Health and Social Rehabilitation Services Administration of Louisiana to provide EPSDT services to the city. The City Health Department bills HSRSA per visit by EPSDT eligibles. Under a DHEW grant, the city has developed a computerized data collection and billing system.

EPSDT INFORMATION FLOW

NEW ORLEANS

ORGANIZATION



INFORMATION FLOW

STRUCTURE	FILE SETS
EPSDT INITIATION, PLANNING AND POLICY HSRSA CONTRACTS WITH NEW ORLEANS HEALTH TO PROVIDE EARLY AND PERIODIC SCREENING AND DIAGNOSIS, AND TO BILL HSRSA FOR THE COSTS OF SERVICES TO THE CHILD ON A PER-VISIT BASIS. NEW ORLEANS HEALTH DEPARTMENT WILL ALSO FURNISH HSRSA WITH FISCAL AND STATISTICAL INFORMATION AND ACCESS TO ADMINISTRATIVE HEALTH RECORDS.	COOPERATIVE HEALTH INFORMATION SYSTEMS (DHEW - HSMHA) AWARDED NEW ORLEANS DEPARTMENT OF HEALTH A GRANT TO ESTABLISH A COMPUTERIZED DATA COLLECTION AND BILLING SYSTEM.
ELIGIBILITY DETERMINATION AND ID NUMBER (AFDC, FC, AND SSI UNDER 21) A CLIENT'S ID NUMBER IS THEIR SOCIAL SECURITY OR PARENT'S SOCIAL SECURITY NUMBER PLUS A TWO DIGIT CODE IDENTIFYING CHILD'S BIRTH STATUS.	DIVISION OF FAMILY SERVICES UNDER HSRSA SUBMITS AN UPDATED QUARTERLY TAPE OF ELIGIBLES TO NEW ORLEANS. NEW ORLEANS UPDATES THEIR ELIGIBILITY FILE WEEKLY WITH THE DAILY UPDATES SENT BY FAMILY SERVICES, AND SENDS THIS LIST TO EACH OF THE TEN NEW ORLEANS HEALTH CLINICS.
PROVIDER RECRUITMENT SCREENING AND DIAGNOSIS INCLUDING DENTAL SCREENING AND SOME SERVICES IS PERFORMED BY LOCAL HEALTH CLINICS. FURTHER TREATMENT IS PERFORMED BY TITLE V AGENCIES, STATE HEALTH PROGRAMS AND PRIVATE PHYSICIANS LICENSED BY STATE MEDICAL ASSOCIATION.	

STRUCTURE	FILE SETS
NOTIFICATION AND SCHEDULING FOR SCREENING	
PUBLIC HEALTH NURSES MAKE HOME VISITS AND EXPLAIN THE EPSDT PROGRAM. APPOINTMENTS CAN BE MADE AT THIS TIME OR THE PARENT CAN SCHEDULE OR JUST BRING THE CHILD FOR SCREENING.	
NO SHOWS AND PERIODICITY	
RECORDS ARE KEPT BY THE LOCAL HEALTH CLINIC AND THUS PERIODICITY SCREENING PROCEDURES CAN BE DETERMINED. IF AN APPOINTMENT IS SCHEDULED THE CLINIC CAN CHECK ON NO SHOWS.	
SUPPORTIVE SERVICES	
THE HEALTH CLINICS WORK IN CONJUNCTION WITH THE LOCAL SOCIAL SERVICE WORKER TO PROVIDE TRANSPORTATION AND DAY CARE.	
FAMILY CASE HISTORY	
THE LOCAL HEALTH CLINIC HAS THIS INFORMATION AVAILABLE IN THE PATIENTS FOLDER.	THE PATIENT REGISTRATION FORM IS STORED ON TAPE AND UPDATED WHEN CHANGES ARE NOTED.
REIMBURSEMENT FOR SCREENING	
NEW ORLEANS USES AN ENCOUNTER FORM TO RECORD ANY DELIVERY OF HEALTH CARE SERVICES BY A HEALTH CARE PROVIDER. SCREENING AND DENTAL ENCOUNTER FORMS ARE BILLED TO HSRSA UNDER AFDC. THE FIRST TIME AN INDIVIDUAL RECEIVES SERVICES FROM ANY AGENCY IN THE CITY HEALTH DEPARTMENT'S HEALTH CARE DELIVERY SYSTEM THEY WILL BE REGISTERED BY FILLING OUT A PATIENT REGISTRATION FORM. (SEPARATE FORM FOR EACH ADULT AND CHILD) THE ID NUMBER RECORDED ON THE ENCOUNTER FORM MUST CORRESPOND WITH ID ON PATIENT'S REGISTRATION FORM.	ENCOUNTER FORMS ARE FIRST SENT TO NEW ORLEANS CENTRALIZED HEALTH COMPUTER. THESE FORMS ARE FIRST CHECKED AGAINST THE ELIGIBILITY FILE AND REGISTRATION FILE. REIMBURSEMENT RATES ARE THE SAME AS STATE OF LOUISIANA. THE ENCOUNTER FORMS ARE THEN USED TO UPDATE THE HEALTH MASTER, AND CREATE BILLING TAPE WHICH IS SENT TO HSRSA.
SCREENING EVALUATION AND UR	
CITY OF NEW ORLEANS HEALTH DEPARTMENT HAS RESPONSIBILITY.	
MEDICAL CASE HISTORY	
LOCAL HEALTH CLINIC FOLDER HAS RECORD OF SERVICES RENDERED BY HEALTH DEPARTMENT.	THE NEW ORLEANS HEALTH MASTER HAS A RECORD FOR EVERY ENCOUNTER FORM SUBMITTED. THE PATIENTS PROFILE IS A REGULAR REPORT PRINTED BY THE COMPUTER AND SENT TO LOCAL HEALTH CLINICS.
REFERRAL FOR DIAGNOSIS AND TREATMENT	
EACH LOCAL HEALTH CLINIC MUST REFER CLIENTS TO AN AUTHORIZED PROVIDER FOR ANY NECESSARY FOLLOW-UP DIAGNOSIS AND TREATMENT. IF A CLINIC DOES ANY TREATMENT OTHER THAN PROCEDURES REQUIRED UNDER EPSDT, IT SUBMITS AN ENCOUNTER FORM TO HSRSA AND DESIGNATES MEDICAID AS THE SOURCE OF PAYMENT.	THE PATIENT PROFILE REPORT SHOWS IF ANY FOLLOW UP IS NEEDED.
REIMBURSEMENT FOR DIAGNOSIS AND TREATMENT	
FURTHER TREATMENT MAY ALSO BE PROVIDED UNDER MEDICAID PLAN BY TITLE V AGENCIES, STATE HEALTH PROGRAMS AND PRIVATE PHYSICIANS LICENSED BY STATE MEDICAL ASSOCIATIONS. BILLS ARE SUBMITTED TO LOUISIANA DIVISION OF FAMILY SERVICES	DFS CHECKS BILLS MANUALLY AND REIMBURSES USUAL CUSTOMARY FEE OR FEE SCHEDULE (WHICHEVER IS LESS). THIS IS STORED ON PHYSICIAN CLAIM FILE.

OKLAHOMA

EPSDT RESPONSIBILITY

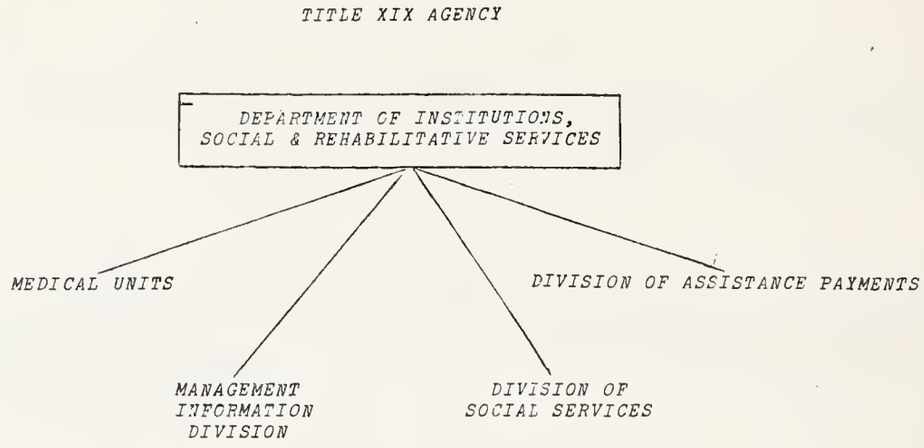
The Department of Institutions, Social, and Rehabilitative Services is the Title XIX umbrella agency in Oklahoma.

No formal contract exists delineating EPSDT responsibilities within the agency, however, the Division of Assistance Payments determines eligibility. The Medical Unit performs UR and medical supervision, the Division of Social Services performs casework, and the Management Information Division maintains computerized EPSDT files.

EPSDT INFORMATION FLOW

OKLAHOMA

ORGANIZATION



INFORMATION FLOW

STRUCTURE	FILE SETS
EPSDT INITIATION, PLANNING, AND POLICY	
NO FORMAL INTER-AGENCY CONTRACT. INFORMAL TASK FORCE OPERATING AMONG ALL THE DIVISIONS RESPONSIBLE FOR EPSDT ADMINISTRATION AND OPERATIONS.	
ELIGIBILITY DETERMINATION AND ID NUMBER	
ASSISTANCE PAYMENTS DETERMINES ELIGIBILITY EVERY SIX MONTHS. (AFDC, CUSTODY OF THE STATE OR FINANCIALLY ELIGIBLE FOR MEDICAL ASSISTANCE PROGRAM). AT ONSET OF ELIGIBILITY THE ASSISTANCE PAYMENTS WORKER FILLS OUT AN INTRA-AGENCY REFERRAL FORM WHICH IS SENT TO THE SOCIAL SERVICE WORKER SHOWING IF THERE IS A NEED FOR SCREENING.	THE CASE INFORMATION SYSTEM CONTAINS ELIGIBILITY INFORMATION. THIS SOPHISTICATED COMPUTER SYSTEM CROSS-REFERENCES ID NUMBER TO DETERMINE CLIENT'S PAST ELIGIBILITY.
PROVIDER RECRUITMENT	
ANY MEDICAL OR OSTEOPATHIC PHYSICIAN AND DENTIST WHO SUBMITS A BILL AND SIGNS THE MEDICAID AGREEMENT IS ELIGIBLE TO PERFORM SCREENING, DIAGNOSIS AND TREATMENT	ONCE A PHYSICIAN OR CLINIC SUBMITS A BILL THEY ARE PUT ON THE PHYSICIAN CLAIM FILE. VENDOR NUMBER IS THEIR SOCIAL SECURITY NUMBER.

STRUCTURE	FILE SETS
NOTIFICATION AND SCHEDULING FOR SCREENING	
UPON RECEIVING THE INTRA-AGENCY REFERRAL THE SOCIAL SERVICE WORKER WILL CONTACT THE RECIPIENT. AT THIS TIME THE SOCIAL SERVICE WORKER ASSISTS THE PARENT IN DETERMINING SCREENING NEED, SCHEDULING APPOINTMENT AND COLLECTING HEALTH HISTORY DATA. PARENT MUST SIGN FORM REQUESTING SCREENING. ONE COPY OF HEALTH HISTORY FORM IS PRESENTED TO THE DOCTOR AT SCREENING.	SOCIAL SERVICE WORKER KEEPS HARDCOPY OF INDIVIDUAL HEALTH RECORD. THEY ALSO SUBMIT A SERVICE INFORMATION FORM SHOWING THE REQUEST FOR SCREENING OR REFUSAL OF SERVICE. THIS SERVICE INFORMATION FORM IS STORED IN THE CASE INFORMATION SYSTEM.
NO SHOWS AND PERIODICITY	
RESPONSIBILITY OF SOCIAL SERVICE WORKER WHO CAN USE HIS OR HER FILES AND CLIENT STATUS REPORT. PHYSICIAN CAN ESTABLISH HIS OWN PERIODICITY SCHEDULE FOR ELIGIBLE CLIENTS (LIMITED TO ONE SCREEN/YEAR).	EPSDT FLYER IS SENT TO RECIPIENT ANNUALLY ON THE ANNIVERSARY OF THE MONTH OF CERTIFICATION FOR ASSISTANCE.
SUPPORTIVE SERVICES	
REQUEST FORMS CAN BE SUBMITTED BY THE CLIENT FOR TRANSPORTATION, DAY CARE, ETC. OR THE SOCIAL SERVICE WORKER CAN MAKE ARRANGEMENTS FOR SUPPORTIVE SERVICES INCLUDING PAID TRANSPORTATION.	REQUEST FORMS ARE ROUTED TO THE SOCIAL SERVICE WORKER FOR THE CLIENT.
FAMILY CASE HISTORY	
THE PAYMENT ASSISTANCE WORKER OBTAINS THIS INFORMATION AT ONSET OF ELIGIBILITY. THE SOCIAL SERVICE WORKER CAN SUBMIT FORMS TO UPDATE THIS INFORMATION.	THE MULTITUDE OF FORMS DOCUMENTING SOCIAL SERVICES COMPRISE A COMPLETE FAMILY HISTORY WHICH IS STORED AND CAN BE PARTIALLY RETRIEVED BY IBM DISPLAY TERMINALS UTILIZING THE CASE INFORMATION SYSTEM.
REIMBURSEMENT FOR SCREENING	
PHYSICIANS FILL OUT PHYSICIANS SCREENING REPORT FORM (ADM-36-K) WHICH IS ALSO SIGNED BY PARENT. PHYSICIAN OR DENTIST SHOULD SUBMIT THIS REPORT WITHIN SIXTY DAYS OF SCREENING.	EACH PHYSICIAN'S SCREENING REPORT FORM GENERATES FIVE DIFFERENT RECORDS ON THE PHYSICIAN'S CLAIM FILE. REIMBURSEMENT AMOUNTS ARE DETERMINED BY USING THE VENDOR FILE. THIS FORM IS ALSO USED BY THE CLIENT INFORMATION SYSTEM TO GENERATE AND UPDATE THE CLIENT STATUS REPORT WHICH IS SENT TO SOCIAL SERVICE WORKERS.
SCREENING EVALUATION AND UR	
UTILIZATION REVIEW THROUGH MEDICAL UNITS STAFF.	COMPUTER PROGRAMS TO FLAG EXCESS BILLING AMOUNTS, MORE THAN ONE SCREENING PER YEAR AND IMPROPER SCREENING PROCEDURES.
MEDICAL CASE HISTORY	
THIS IS KEPT BY PHYSICIAN AND SOCIAL SERVICE WORKER KEEPS A FOLDER OF MEDICAL SERVICES PERFORMED AND/OR NEEDED.	THE PHYSICIAN'S CLAIMS FILE CAN BE SORTED TO PRODUCE A MEDICAL CASE HISTORY.
REFERRAL FOR DIAGNOSIS AND TREATMENT	
DENTISTS MUST SUBMIT A NOTIFICATION OF NEEDED MEDICAL SERVICES. THE PHYSICIAN WHO PERFORMED THE SCREENING CAN EITHER PERFORM TREATMENT OR REFER CLIENT TO ANOTHER PHYSICIAN. THE SOCIAL SERVICE WORKER CAN ASSIST BY USING THE CLIENT STATUS REPORT AND REFERRING THE CLIENT.	THESE ARE REVIEWED BY A DENTAL EVALUATION UNIT.
REIMBURSEMENT FOR DIAGNOSIS AND TREATMENT	
THE PHYSICIAN OR DENTIST SUBMITS THE ADM-36-K BILLING FORM.	EACH BILLING FORM GENERATES FIVE DIFFERENT RECORDS ON THE PHYSICIANS CLAIMS FILES. REIMBURSEMENT AMOUNTS ARE DETERMINED BY USING THE VENDOR FILE.
DIAGNOSIS AND TREATMENT EVALUATION AND UR	
UTILIZATION REVIEW THROUGH MEDICAL UNITS STAFF.	COMPUTER PROGRAMS FLAG MORE THAN FOUR OFFICE VISITS A MONTH, HIGH VOLUME VENDORS AND QUESTIONABLE BILLS.

SOUTH CAROLINA

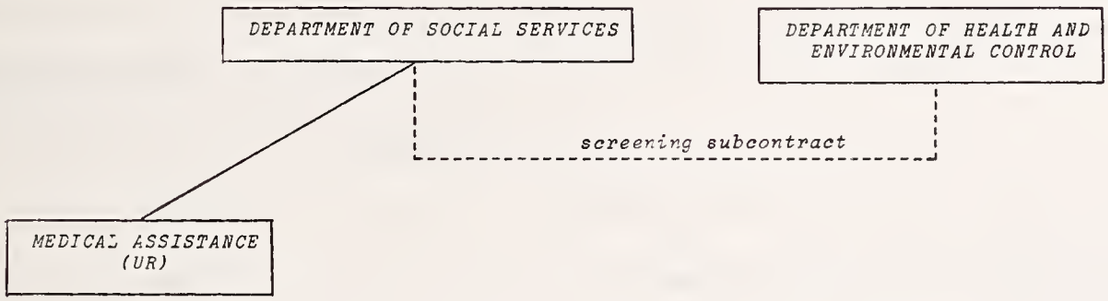
EPSDT RESPONSIBILITY

A screening subcontract exists between the Department of Social Services (the Title XIX agency) and the Department of Health and Environmental Control. The former retains administrative responsibility and performs case work. The Department of Health provides screening through local public health clinics. The Medical Assistance Section of DSS performs UR.

EPSDT INFORMATION FLOW

SOUTH CAROLINA

ORGANIZATION



INFORMATION FLOW

STRUCTURE	FILE SETS
EPSDT INITIATION, PLANNING AND POLICY	
DSS CONTRACT WITH HEALTH STIPULATES REIMBURSEMENT RATES FOR SCREENING.	
ELIGIBILITY DETERMINATION AND ID NUMBER	
DSS VERIFIES ALL ELIGIBILITY REQUESTS. ELIGIBILITY NUMBER IS NOW THE SAME AS PARENTS' MEDICAID NUMBER. THEY ARE THINKING ABOUT USING SOCIAL SECURITY NUMBER.	CREATE DSS ELIGIBILITY FILE. THIS PROGRAM ALSO GENERATES AN 817 INITIAL SCREENING FORM. THIS FILE IS UPDATED DAILY.
CATEGORICALLY NEEDY ONLY.	
PROVIDER RECRUITMENT	
SCREENING: DEPARTMENT OF HEALTH (ANY SOUTH CAROLINA LICENSED HEALTH CLINIC).	
DIAGNOSIS AND TREATMENT: ANY LICENSED DOCTOR OR DENTIST, IF DO NOT WANT TO BE PART OF PROGRAM THEY MUST REQUEST WITHDRAWAL.	
NOTIFICATION AND SCHEDULING FOR SCREENING	
DSS SENDS A LIST AT IN-TAKE AND RECERTIFICATION TO THE CASEWORKER WHO SCHEDULES APPOINTMENTS.	DSS USES ELIGIBILITY FILE TO NOTIFY CASEWORKER OF APPOINTMENT REQUESTED.

STRUCTURE	FILE SETS
NO SHOWS AND PERIODICITY	
THE CASEWORKER (DSS) MUST BE PRESENT AT THE SCREENING. ALSO AFTER NINETY DAYS THE CASE WORKER GETS A PRINT-OUT OF SCREENING RESULTS.	DSS PRINTS-OUT SCREENING RESULTS FROM 817 SCREENING FORMS.
PERIODICITY MUST BE CHECKED BY THE CASE WORKER.	
SUPPORTIVE SERVICES	
PAYMENT FOR TRANSPORTATION MUST (UNLESS EMERGENCY) BE PRE-AUTHORIZED BY DSS. DSS ARRANGES TRANSPORTATION WITH LOCAL OEO.	DSS CONTRACT WITH OEO FOR TANSPORTATION FOR ALL SOCIAL SERVICES. SCREENING HAS PRIORITY.
FAMILY CASE HISTORY	
THE CASE WORKER COMPLETES A FORM AND KEEPS A COPY FOR HIS RECORDS.	HARDCOPY OF CLIENT INFORMATION SUMMARY IS KEPT BY CASE WORKER AND DSS.
REIMBURSEMENT FOR SCREENING	
TOP PART OF 817 SCREENING FORM IS FILLED OUT BY CLINIC AND SENT TO DSS.	DSS CHECKS 817 FORMS AND DETERMINES REIMBURSEMENT AMOUNTS. SERVICE CODES, PROBLEM CODES AND VENDOR NUMBER ARE KEPT AS HISTORY RECORD ON EARLY SCREENING FILE (DSS). DSS ALSO GENERATES A SCREENING RESULT PRINT-OUT SENT TO CASE WORKER.
SCREENING EVALUATION AND UR	
IN CONTRACT DSS CAN INSPECT RECORDS OF HEALTH DEPARTMENT DURING NORMAL WORKING HOURS. HEALTH DEPARTMENT RESPONSIBLE FOR UR.	
MEDICAL CASE HISTORY	
THE DSS CASE WORKER KEEPS A HARDCOPY FILE.	DSS EARLY SCREENING FILE CONTAINS ONE OF EACH: HISTORY RECORD WITH DATE, CASE, VENDOR, PROCEDURES AND PROBLEMS. DENTAL RECORD. DIAGNOSIS AND TREATMENT RECORD. PROCEDURE CODES CHANGE IF MORE THAN ONE TREATMENT IS NECESSARY, HOWEVER, AMOUNT FOR SERVICE IS ACCUMULATED. EXCEPT AN ADDITIONAL RECORD IS GENERATED FOR EACH DIFFERENT PROVIDER FOR UR PURPOSES.
REFERRAL FOR DIAGNOSIS AND TREATMENT	
UNLESS AN EMERGENCY THE SECOND PART OF THE 817 SCREENING FORM (PLAN OF TREATMENT) IS FILLED OUT BY A PHYSICIAN AND SUBMITTED TO DSS. (THE CASE WORKER MUST GIVE THE DOCTOR OR PARENT A COPY OF THE CHILD'S 817).	DSS ADDS THIS TO DIAGNOSIS RECORDS OF EARLY SCREENING FILE AFTER IT HAS BEEN MANUALLY CHECKED. IF PLAN OF TREATMENT IS GRANTED THE 817 IS SENT BACK TO THE PROVIDER AND A COPY IS GIVEN TO CASE WORKER.
REIMBURSEMENT FOR DIAGNOSIS AND TREATMENT	
THE DOCTOR OR DENTIST FILLS OUT THE BC/BS FORM.	BC/BS PAYS DOCTOR OR DENTIST AND SUBMITS A TAPE TO DSS FOR REIMBURSEMENT. DSS UPDATES THE DIAGNOSIS AND TREATMENT RECORD ON EARLY SCREENING FILE.
ALL DENTAL CLAIMS ARE DIAGNOSIS AND TREATMENT.	DSS UPDATES THE DENTAL RECORD ON EARLY SCREENING FILE.
DIAGNOSIS AND TREATMENT EVALUATION AND UR	
THE CASE WORKER HAS THE RESPONSIBILITY OF CHECKING IF TREATMENT IS COMPLETED. IF SO, THE LAST LINE OF THE 817 SCREENING FORM IS COMPLETED AND SENT TO DSS.	DSS CHECKS FOR MORE THAN FOUR VISITS PER MONTH OR $20 FOR PRESCRIPTIONS OR OVER $50 FOR A TREATMENT. THESE CASES ARE GIVEN TO THE UR COMMITTEE.

WASHINGTON

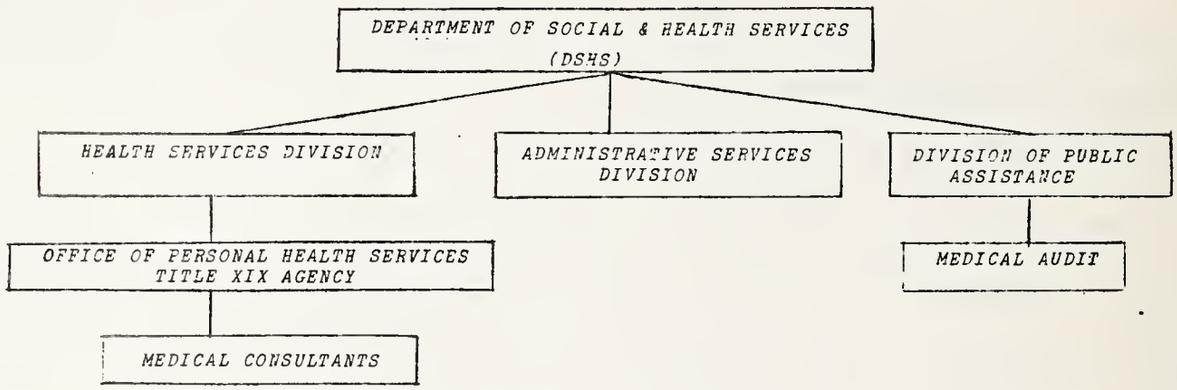
EPSDT RESPONSIBILITY

Washington coordinates its EPSDT efforts through three Divisions of the Department of Social and Health Services. Within this umbrella Department, the Office of Personal Health Services, under the Health Services Division, is the Title XIX agency. The Administrative Services Division assigns case numbers, the Division of Public Assistance performs casework, and Medical Audit under DPA reviews provider claims.

EPSDT INFORMATION FLOW

WASHINGTON

ORGANIZATION



INFORMATION FLOW

STRUCTURE	FILE SETS
EPSDT INITIATION, PLANNING AND POLICY	
OFFICE OF PERSONAL HEALTH SERVICES IS THE TITLE XIX ADMINISTRATIVE AGENCY. THE MEDICAL CONSULTANTS, AS REGIONAL REPRESENTATIVES FOR THE OFFICE, ARE RESPONSIBLE FOR PRIOR MEDICAL AUTHORIZATION WHEN NEEDED.	ALL BILLS ARE FISRT REVIEWED BY MEDICAL AUDIT STAFF AND THEN PROCESSED BY DIVISION OF PUBLIC ASSISTANCE.
ELIGIBILITY DETERMINATION AND ID NUMBER	
LOCAL SERVICE WORKERS OF DSHS DETERMINE ELIGIBILITY FOR MEDICALLY AND CATEGORICALLY NEEDY.	A FAMILY IS ASSIGNED A CASE NUMBER AND EACH INDIVIDUAL HAS A PIC NUMBER (INITIALS AND DATE OF BIRTH). THESE NUMBERS AND PERTINENT INFORMATION ARE COMPUTERIZED BY ADMINISTRATIVE SERVICES. LOCAL DSHS OFFICES ALSO ISSUE MEDICAL COUPON BOOKLETS - THESE COUPONS MUST ACCOMPANY VENDOR BILLS.
PROVIDER RECRUITMENT	
THERE ARE FOUR VENDOR ID LISTS: - MEDICAL SCREENING (HEALTH CLINICS AND SOLO PRACTITIONERS) - DENTAL SCREENING - MEDICAL DIAGNOSIS AND TREATMENT - DENTAL DIAGNOSIS AND TREATMENT PROVIDERS MUST SIGN CONTRACTS AND SUBMIT THEM TO OFFICE OF PERSONAL HEALTH SERVICES.	PERSONAL HEALTH SERVICES DETERMINES IF VENDOR IS ACCEPTABLE AND GIVES VENDOR NUMBER LIST TO DIVISION OF PUBLIC ASSISTANCE.

STRUCTURE	FILE SETS
NOTIFICATION AND SCHEDULING FOR SCREENING	
SCHEDULING OF APPOINTMENTS CAN BE MADE BY LOCAL DSHS CASEWORKERS, CLINICS ENROLLED FOR SCREENING, OR BY THE PARENT.	EVERY SIX MONTHS DSHS SENDS FLYER ON EPSDT.
NO SHOWS AND PERIODICITY	
LOCAL SOCIAL SERVICE WORKERS ARE RESPONSIBLE FOR NO SHOWS. THIS IS AN INFORMAL SYSTEM AND INDIVIDUAL PROVIDERS CAN ALSO CHECK NO SHOWS AND PERIODICITY.	A LOG OF SCREENING REQUESTS AND REFERRALS IS KEPT BY LOCAL DSHS OFFICE TO ASSURE RECEIPT OF SERVICES. THIS LOG CAN BE AUDITED BY STATE DSHS.
SUPPORTIVE SERVICES	
TRANSPORTATION REQUIRES PRIOR APPROVAL OF MEDICAL CONSULTANT OR LOCAL DSHS SERVICE WORKER.	
FAMILY CASE HISTORY	
RESPONSIBILITY OF LOCAL DSHS SERVICE WORKER.	LOCAL DSHS SERVICE WORKER KEEPS A HARDCOPY FOLDER FOR EACH CASE.
REIMBURSEMENT FOR SCREENING	
VENDOR SUBMITS EARLY SCREENING AND DIAGNOSIS BILLING FORM TO MEDICAL AUDIT SECTION. ATTACHED TO THE BILL MUST BE THE CLIENT ELIGIBILITY COUPON.	MEDICAL AUDIT FIRST MANUALLY REVIEWS SCREENING FORM FOR UR. FORM IS THEN STORED ON PUBLIC ASSISTANCE BILLING FILE. PROVIDER MUST SUBMIT MONTHLY A STATISTICAL REPORT OF INDIVIDUALS RECEIVING SCREENING SERVICES.
SCREENING EVALUATION AND UR	
MEDICAL CONSULTANT PERFORMS SITE VISITS FOR PARTICIPATING HEALTH CLINICS.	IF MEDICAL AUDIT FINDS UNUSUAL BILLS THE MEDICAL CONSULTANT INVESTIGATES FOR DSHS.
MEDICAL CASE HISTORY	
LOCAL DSHS WORKERS AND MEDICAL CONSULTANTS CAN REQUEST A PRINT OUT OF AN INDIVIDUALS RECORD OF ASSISTANCE PAID.	PUBLIC ASSISTANCE CAN PROVIDE UPON REQUEST RECORD OF ASSISTANCE PAID FORM: - PROVIDER NUMBER - PROCEDURE CODE AND AMOUNT - DATE PAID.
REFERRAL FOR DIAGNOSIS AND TREATMENT	
SCREENING VENDORS MUST BE ABLE TO REFER FOR FOLLOW-UP TREATMENT. PRIOR APPROVAL FOR DENTAL TREATMENTS IS AUTHORIZED BY WASHINGTON DENTAL SERVICE.	THIS INFORMATION IS TAKEN OFF OF SCREENING FORM AND INCLUDED IN LOCAL DSHS LOG OF SCREENINGS REQUESTED AND REFERRALS.
REIMBURSEMENT FOR DIAGNOSIS AND TREATMENT	
EVEN IF DIAGNOSIS AND TREATMENT TAKES PLACE AT SAME TIME AS SCREENING, TWO BILLS ARE SUBMITTED. A SEPARATE BILLING FORM WITH ATTACHED MEDICAL COUPON IS SUBMITTED TO MEDICAL AUDIT SECTION. DENTAL BILLING TO FISCAL INTERMEDIARY (WASHINGTON DENTAL SERVICE).	MEDICAL AUDIT MANUALLY CHECKS BILLS AND REIMBURSEMENTS ARE DETERMINED BY PROCEDURE CODES OR USUAL AND CUSTOMARY FEES (WHICHEVER IS LESS). THESE BILLS ARE THEN PROCESSED BY DIVISION OF PUBLIC ASSISTANCE AND STORED ON BILLING FILE.
DIAGNOSIS AND TREATMENT EVALUATION AND UR	
MEDICAL CONSULTANTS CAN PERFORM SITE VISITS TO HEALTH CLINICS PROVIDING DIAGNOSIS AND TREATMENT.	IF MEDICAL AUDIT FINDS UNUSUAL BILLS OR HIGH VOLUME VENDORS THE MEDICAL CONSULTANT INVESTIGATES FOR DSHS.

- MEDICAL CASE HISTORY

  Identifies content of records, organization of files, responsibility for maintaining and storing records, availability and access to patient profile.

- DIAGNOSIS AND TREATMENT REIMBURSEMENT

  Identifies who bills whom, fee schedules, what is stored from billing form, where it is stored and how eligibility is checked.

- DIAGNOSIS AND TREATMENT EVALUATION AND UTILIZATION REVEIW

  Who is responsible and how it is performed.

It should be noted that information contained in the flow chart answers the first two objectives of the site visit, namely:

Describe in place EPSDT efforts;

Determine what data are being recorded.

We have also organized the data presented in the flow chart into a set of decision matrices which permit examination of EPSDT components and data files by state. Appendix B presents the EPSDT State Data File Matrix, while Appendix C presents the EPSDT Component Matrix.

4.2 DESCRIPTION OF STATE EPSDT STATUS

In the effort to understand EPSDT, information from the MSA files were reorganized into seven categories under which may be subsumed all EPSDT functions. The categories listed are detailed in Section 3.1:

Administration

Financing

Provider Agreements

Enrollment

Screening Availability

Diagnosis and Treatment

Case Management

In essence, these categories define the boundaries of a proposed classification system. That is to say, an understanding of the way in which EPSDT functions within these categories, the information which supports these categories, and the way in which this information is used to improve functioning within these categories defines both the EPSDT universe and the degree to which evaluation is taking and can take place.

To further our understanding of the present status of EPSDT, we have taken the data from the interviews and reorganized it for discussion purposes into seven categories. At this time we plan to review the state status of EPSDT in terms of current structures and operations emphasizing the dynamic and evolutionary nature of EPSDT development. Included in this discussion is the identification of those barriers which mitigate against successful functioning within these categorical dimensions. It is expected that this section will serve as the basis for a subsequent effort, namely classifying data systems and files and their use in evaluation of EPSDT. This section of the report then also serves to fulfill our third objective: What uses are being made of EPSDT data?

Parenthetically, it should be noted that these discussions do not identify

status and problems on a state by state basis. To the contrary, individual state identities have been submerged to maintain confidentiality of information provided by state personnel. The reason is that this effort was not perceived as a state evaluation but instead was part of the effort necessary to build an evaluation system based upon the concept of information classification rather than specification.

This mission was explained to state personnel during site visits and we feel that this position resulted in our obtaining information which otherwise would not have been disclosed. To reiterate, the following sections describe the nature of structures extent in the states and the barriers to effective functioning without identifying specific states.

4.2.1 ADMINISTRATION

EPSDT administration and operations show a wide structural range across the states. Organizational structures range from highly centralized agencies to a diffusion of responsibility through a large number of pre-existing State Offices. These differences reflect organizational strengths which in turn are related to the operational interpretation of EPSDT.

These bureaucratic differences serve to influence all program operations. In the course of this section the organization of EPSDT bureaucracy is detailed and its effects on policy, planning, objectives and information systems are considered.

EPSDT ORGANIZATIONAL STRUCTURES

EPSDT activities are distributed under three headings: administration; medical services; and non-medical services. The distribution of activities follows:

ADMINISTRATION	MEDICAL AND DENTAL SERVICES	NON-MEDICAL SERVICES
fiscal responsibility evaluation and quality control reporting provider enrollment provider reimbursement rates	screening diagnosis treatment	eligibility determination marketing and scheduling support services case management

The administration and operation of EPSDT clearly involves a large variety of offices. The types of offices encountered in the eight states visited that perform direct or indirect EPSDT activities follows:

	ACTIVITY TYPE		
LEVEL OF OPERATION:	ADMINISTRATION	MEDICAL AND DENTAL SERVICES	NON-MEDICAL SERVICES
State Health and Welfare Divisions	finance fiscal intermediary liaison data processing	child health medical evaluation categorical programs	public information field office supervisor eligibility determination social services EPSDT coordinator
Other State Offices	budget office treasurer controller governor OEO		
State Regional or County	statistics billings records	providers - public - private	eligibility determination social services EPSDT coordinator

It can be concluded that the success of EPSDT requires a highly sophisticated level of coordination.

Administrative and operational functions of EPSDT have been nested in three structures at the state level: Departments of Welfare; Departments of Health; and single state umbrella agencies which encompass both health and welfare.

The single state agency for Title XIX in each state visited is either the Welfare Department or the umbrella department in which a Welfare Division is nested. Where formal agreements are in effect, the two agencies involved are Welfare and Health; the former retaining ultimate responsibility and authority.

In the eight states, three independent Departments of Welfare and three Divisions of Welfare have entered into contractual agreements with corresponding Departments or Divisions of Health. In one state without a written agreement, authority resides in the umbrella agency per se rather than any division. In another state without a contract, authority for Title XIX resides in one office of the umbrella agency.

Umbrella agencies offer an advantage over separate departments; namely, policy making for the large number of offices involved is centralized.

This increases the potential ease with which a comprehensive EPSDT effort may be integrated within pre-existing bodies. It is no coincidence that two states which operate under umbrella agencies do not have formal interagency agreements.

States which function with discrete Departments of Health and Welfare have a structural barrier to overcome in defining mutually compatible policies. Although each department can assign internal priorities, the interaction between departments dictates the existence of an outside arbiter to resolve disputes. This arbiter is, logically, the State Executive. Thus, policy resolution occurs outside the normal bureaucratic channels and injects a great deal of potential political noise into policy definition and implementation.

One important element of administration is the level of communications that exist between agencies. There are formal and informal means of maintaining information flows, and all states necessarily operate under some functional information exchange system. The interagency task force as a formal body fulfills this need in one state, but another has a highly evolved informal system of phone, memo, and conference. This information process is critical for the effective integration of the EPSDT subsystems.

Identifiable personnel assigned to EPSDT are also significant elements of administration. All states have mixes of personnel assigned solely

to EPSDT and personnel with shared responsibilities, but there are quantitative degrees of this. For instance, one state has fifty slots budgeted for EPSDT services, while others merely add on to existing worker responsibilities. These levels are important indicators of the degree of program function.

Finally, EPSDT necessarily links public agencies with the private sector: medical providers, non-medical service providers, and fiscal intermediaries.

In general what we have found is that despite the myriad of possible interactions between various agencies EPSDT can be described functionally under one of two operational definitions:

- EPS plus Title XIX (EPS-DT)
- EPSDT plus Title XIX (EPSDT-DT)

In the former case the program is operated as early and periodic screening, or as early screening. The primary focus is directed to inputting children to screening with the expectation that providers already servicing Title XIX can be used for referrals.

In the latter cases the program functions in a highly structured manner with well-defined linkages between screening, diagnosis and treatment. These programs may also permit screening, diagnosis and treatment to be provided concurrently through normal Title XIX channels.

The EPS-DT/EPSDT-DT groupings are identifiable levels of program development and integration in the eight states visited. There are six states in the first category and two in the second. The latter two operate under umbrella agencies, one with a formal interagency task force for EPSDT, the other with an intricate network of contacts among administrative personnel without formal departmental sanction.

The other six states are divided between umbrella agencies (2), and discrete departments (4). None of these have formal task forces, but interagency contact is frequent if informal.

OBJECTIVES AND MANAGEMENT PLANNING

The objectives of the states visited cluster about two concerns:

- Threshold or Compliance
- Refinement or Maximization

The former is identified by a concern with Federal sanctions - a problem for all states - while the latter defines its thrust as improvement of program effectiveness and efficiency. A listing obtained during the interviews and the number of states which articulated each follows:

1. Compliance with Federal regulations (8 states).
2. Screen a defined quota of eligibles (4 states).
   Allocate quotas by county (1 state).
3. Implement periodicity quotas (1 state).

4. Eliminate no-shows for screening (2 states).
5. Enroll adequate providers (2 states).
6. Centralize EPSDT and integrate screening with diagnosis and treatment (3 states).
7. Provide health education and related services (2 states).
8. Improve record keeping and statistics (5 states).
9. Improve evaluation (1 state).

It must be added that all states could articulate any of these objectives. The importance of this distribution is that they are ones receiving priority attention from responsible authorities.

The objective receiving the most mention is "Improve record keeping and statistics". As initial struggles with EPSDT are surmounted attention has been directed to problems of monitoring, evaluation and planning.

One local project, encompassing a major population center, has evolved the rudiments of a highly sophisticated tracking and recording system to assist in planning. The project director hopes that his data base will permit determination of utilization and penetration among EPSDT eligibles allowing him unique opportunities to plan and estimate services and costs.

Other states sense the opportunities inherent in efficient data collection

and are attempting to upgrade both hardware and software capabilities. (The flow charts display the current data capabilities of the states.)

It is important at this time to emphasize the priority placed on this objective by the states. This indicates the extent of future interest and suggests that more resources are becoming available in the states which will allow personnel to direct more and more attention to planning and data support systems.

Management styles evidenced were a rough mixture of "management by objectives" and "management by crisis" (this latter description given by one state official.

Those states which indicated a detailed set of objectives (county quotas, follow-up refinements, record streamlining, etc) strongly endorsed the specification of benchmarks by which to monitor program attainment. But formal MBO systems seemed to be the bane of most of these states, occuppying scarce staff in constructing and refining plans which they seemed to feel serve the needs of the political actors primarily. This view was expressed in at least three states, and there were intimations of similar views in other states. This feeling occurs whether or not a formally sanctioned MBO process existed. Finally, it should be recognized that since no agency functions devoid of expectations or outside direction, MBO is a functional presence in all states visited.

Management by crisis (MBC) is a more popular mode of operation in the states, if only because necessity so dictates. First, many personnel working in EPSDT have additional responsibilities. Accordingly their attention is diverted to which ever "squeaky wheel" squeaks loudest.

Second, the rapid implementation of EPSDT in the wake of increasing Federal pressure and court suits produced uneven subsystems whthin the EPSDT network. Consequently, attention is often diverted to the most glaring deficiencies. This preoccupation with daily crises necessarily depletes attention otherwise available for systemic and future considerations.

All states visited listed explicit objectives, however, it would appear that those they choose to articulate are highly indicative of the level of program evolution and refinement. Thus, an initial and struggling EPSDT effort might set a blanket quota of "everybody we can get to screening," whereas a more refined effort is capable of specifying screening quotas by county.

Finally the extent to which objectives are specified may be seen as an indicator of program confidence and direction, stemming in part from the quality and currency of information available to administrators and planners.

INFORMATION SYSTEMS

All eight states have sophisticated computer capability. However the range of information systems in place was enormous. Nevertheless the hardware is adequate for any analytic procedures which might be requested.

The real problems lie in the diffuse and fragmentary way in which EPSDT information systems have been developed. These problems may be described as follows:

- the data for all aspects of EPSDT may be in two or more computers in separate agencies.
- the software has not been developed to adequately store, sort, and integrate the various files on which EPSDT is based.
- the data requirements, and the modes of analysis have not been adequately defined.

No aspect of EPSDT is under greater scrutiny. The reason being that as EPSDT operations have mushroomed, so has the volume of data and the requests for compilations of that data. It is impossible to overemphasize the importance of quality information to any program evaluation model. The importance is recognized in the states, and great efforts are being made to develop systems tailored to the unique needs of EPSDT.

The computers available at the state level represent vastly disparate technical capabilities. The implication of these differences for EPSDT, however, are not all that important because of the serial nature of the files

maintained. Much more important is the access EPSDT personnel have to the equipment. For example, states with umbrella agencies may have centralized computer facilities serving users from all social service programs which increases distance between users and programmers and counters the advantages of a unified data system. In other instances we found that two states with discrete agencies have two separate computers, one in health and one in welfare further confusing data consolidation.

Another complication occurs in the states which use fiscal intermediaries for dental or medical services. In at least three states, three computers are processing data from separate aspects of EPSDT. These states are in the throes of attempting to integrate their separate files, but if the experience in other states is any guide, the lag time may be upwards of 18 months to two years. If this holds true for these states, the probability is that less evolved states will not have integrated information systems for several years to come.

This finding has grave implications for Federal monitoring efforts, and reinforces the notion that a data classification system which is built upon present capabilities holds more hope for success than data specification models. Particularly since the need for evaluation is immediate and cannot be deferred, say four to five years.

There are several files involved in EPSDT data processing across the states, however, they may be subsumed under four basic categories. These are:

- eligibility file
  - client history
- vendor file
- screening claims file
- diagnosis and treatment claims file

While the need for these four files is clear, the lack of integration of them within the states remains a problem despite the level of program sophistication.

Aside from problems of separated files, the data also exists in different forms from state to state and level to level within a state. Two states have a computerized record of every screening transaction that has occured since EPSDT was implemented. Others are far short of this, and range from computerized records of current eligibles down to hard copy records in local office case files. Accordingly, in all but two states, the bulk of important data is presently stored in hard copy. What this means is that while there is sufficient data to fullfill any evaluation request, one must recognize the level of effort needed to create new data files and integrate them with existing ones.

States are becoming aware of these conditions and working to develop systems with one or more of the following capabilities:

- combine screening with diagnosis, treatment files to produce a client medical profile.
- combine medical records with client case records, including eligibility, to assist in providing continuity of care across transient eligibility.
- provide on-line remote access to county level.
- provide a tracking, on-line remote systems capable of tying diagnosis and treatment to screening referrals to assure proper follow up.
- maximize centralization of data and computer utilization.
- acquire a computer solely for EPSDT.

None of these objectives is immediately attainable. Beyond the time necessary to develop software and acquire hardware are additional barriers: the distance between systems personnel and EPSDT personnel decreases access and increases the time necessary to complete a task; technical differences such as vendor procedure codes; integrity of data collection; and integration of traditionally separate bodies of data which are not amenable to intuitive or obvious resolution. Finally, specifying data needs may require a combination of decisions and agency politics, a tandem that is rarely congruent within timetable expectations.

Parenthetically, it should be noted that one local project has developed a comprehensive EPSDT data collection and analysis system. The activities being coded are the same as those in other states indicating the possibilities for success of such efforts.

Using a centralized computer facility, the project maintains an eligibility file, patient registration file, and a health master file. The latter is a record of all patient encounters billed through Medicaid.

The records kept are adequate to have produced the following reports on EPSDT utilization:

- patient profile
- registrations by census tract
- morbidity incidence
- distribution maps
- registrations by census tract provider
- clinic utilization by census tract
- purpose of encounter by disposition
- immunization by census tract
- diagnosis by census tract
- services rendered by clinics (monthly)
- daily encounter summary
- daily registration summary
- diagnosis frequencies by provider
- registrations by clinic
- age-race-sex profile by clinic

This project indicates that it is a long way from the perfect system, but these studies are profoundly meaningful to resource allocations, budget de-

terminations, and other objectives. Such an effort is an adequate demonstration that there are no real technical barriers to systems evolution.

Finally we would like to point out that the core of any evaluation model is the data base. In this light it is important to recognize the extent of present state capabilities? Four states have highly evolved data systems, yet only one state and the aforementioned local project are beginning to use the data for planning purposes. However, system designs being contemplated for implementation will be accompanied by an increased use of data for planning and analysis purposes. In those states where designs contain descriptions of available data and the uses to which this data is being being put, we have indicated them in the State Flow Charts. It seems, however, that for present purposes, the answer to our third objective "what uses are being made of the data" is "very little."

SUMMARY

An overview of EPSDT administration, therefore, reflects a range of interpretations of the legislation, from distinct programmatic efforts to add-ons to existing structures. These EPS-DT and EPSDT-DT efforts, however, cannot be interpreted solely in light of authorities and offices.

Less tangible are the historic committments the individual states are prepetuating. Histories of strong public health, charity hospitals, or provision of physician care to the poor are reflections of political

will that have been focused by EPSDT requirements. The ultimate impact of EPSDT will derive not from administrative structures, per se, but from the strength of the determination to fulfill the mandates of EPSDT. This commitment is demonstrated by one state's EPSDT objective; "to screen every eligible child and insure proper treatment". The strength of such a declaration clearly overcomes the bureaucratic structures that fulfill operational and administrative functions.

States with centralized responsibilities in the bureaucracy are seeking further centralization to facilitate integration of the EPSDT sub-systems, but policy and planning considerations must concern internal program goals and the relationship of the program to the greater environment. Thus, one state official explained that responsibility and authority had been spread throughout the state umbrella agency because if too many offices feel left out of a program those offices stimie any initiatives on behalf of the program. An official in another state referred to the constant conflict over interpretations of EPSDT as "a termite war".

All states indicated that the governor's budget office was their major bete noir in terms of money and resources. The budget office directly reflects the priorities of the governor, and thus in those states where EPSDT is considered a high priority item among all state social services programs (perhaps six of the eight visited) the budget office is the primary determinant of resource allocations. This will be discussed further under

financing below, but it may be pointed out here that although monies for provider reimbursement were nowhere found to be in short supply, authorizations for support staff were.

The administration of EPSDT can be viewed, then, as a mixture of pre-existing bodies with special offices or positions created to fill the gaps. Some EPSDT efforts retain their add-on orientation, at least two have assumed somewhat independent and programmatic status. As immediate implementation requirements are met, renewed interest in planning has been stimulated. This in turn, has led to a re-evaluation of data structures and requirements. Although the realization of planned information systems may be years in the making, the emphasis being placed on these needs now heralds a cleaner data base from which evaluation may proceed.

4.2.2 FINANCING

No element so pervades the effective functioning of EPSDT as financing. There are three types of costs associated with EPSDT: direct medical services, direct non-medical services, and administration. A summary of information collected reveals that:

- There is no shortage of funds for provider reimbursement although states close to the 50% matching figure are somewhat more concerned than others.
- There are shortages of government personnel to deliver non-medical support services, as well as concern over the provision and funding of such support services as transportation and child care.

- There is a shortage of administrative personnel at the state level.
- There is a general difficulty in breaking out EPSDT costs, particularly in relating D&T to screening referrals, and in figuring administrative overhead.

The total costs of EPSDT are difficult to compute in any state. Provider reimbursement costs for screening are the easiest to derive. More difficult to ascertain are diagnosis and treatment costs as a consequence of screening outcomes, and indirect costs.

Screening reimbursement rates vary greatly both between and within some states. The rates are of two types: per capita and per procedure. Medical screening rates range from $8.50 for an initial screen to $27.50 although one state is proposing a clinic rate several dollars higher than this latter figure. Only one state has a flat per capita rate, the others pay additional amounts for special tests or procedures. Rescreening rates range from $6.30 to $22.50.

Dental screens range from $5.00 to $18.00, with extra fees in some states for bite-wing x-rays, prophylaxis, or flouride treatment provided during the screening. Two states bypass dental screening altogether in favor of referring all eligibles for diagnosis and treatment and thus do not have a screening rate. Two others incorporate an examination of the mouth into the medical screening.

The provider reimbursement rate times the number of clients screened or procedures performed produces a sub-total of screening costs. Although totals were not available for all states, it would appear that with a single exception states have not expended or projected expenditures in excess of $2.5 million for the present annual year, a figure which includes the Federal share.

Non-medical services such as transportation or day care are also part of EPSDT expenditures, but they are generally not recorded as such. Transportation which must be provided to eligibles who request the service is provided in a wide variety of ways. One state has signed a contract with an OEO project to provide transportation for all social service programs. Other states rely on case worker automobiles, cash allowances in the welfare grant or voluntary agencies to carry clients to the screening appointments. The provision of transportation in all but one state is rather ad hoc and informal, the bane of cost accounting. No state provided transportation expenditure data. The fact that many clients are somehow making it to the provider suggests that either the need for transportation is limited or that the costs are negligible enough not to warrant efforts at special appropriations to cover the need. The latter explanation is probably closer to the truth.

Data on other support services costs were unavailable. One state claimed that every activity associated with EPSDT could be costed, but no data was provided.

Caseworker costs are not always charged to EPSDT. One state charges all caseworker costs to the Welfare Department, another two charge them to Title IV(a) funds. One state has the capability to compute exact personnel costs because part of each client's screening record notes the amount of time each category of worker spent with the client.

Although caseworkers are devoting large amounts of time to EPSDT processes, few states currently possess the capability to determine the costs that could be charged to EPSDT. The multiplicity of duties and services performed by caseworkers mitigates against any easy solution. However, in those states where EPSDT caseworkers are a line item in the budget (2) this difficulty could be largely eliminated.

The provision of diagnosis and treatment as a result of a screening flag represents the greatest challenge to accounting for the costs of EPSDT. Diagnosis and treatment reimbursements are, of course, readily available, but the link to screening is generally either very weak or non-existant. This is a problem directly traceable to the quality of the records maintained and the degree to which the various records are centralized and computerized. This will be discussed in greater detail in further sections. Suffice to say that unless referral records show the abnormality detected in screening, and the physician's treatment records are tied to that referral form, then there is no means to discriminate between diagnosis and treatment from screening and other diagnosis and treatment.

There are four states in which treatment may occur at the same time as screening, and this represents a partial solution to linkage with D&T. No state, however, provided any D & T cost estimates or expenditures arising from screening. The increasing sophistication of record keeping for screening examinations is not being matched by sophisticated linkages with treatment records.

One state was able to specify its EPSDT administration costs, while another state did provide an estimate. Both figures ran to approximately 3% of total costs. One other state claimed the ability to break out administrative costs, but figures were not offered. Two states said that "frankly we have no idea."

Accounting systems are being planned to identify administrative costs, but the accuracy of the figures will depend upon the quality of records and the degree to which EPSDT is submerged in other Title XIX activities and accounts.

MEDICAID DOLLAR

Medicaid dollars receive various priorities among the total dollars available from Federal and state programs. One state explicitly uses Medicaid as the last dollar, another designates Medicaid as the first dollar. One other state designates Medicaid as a "semi-last" dollar, with specific provider resources listed to be charged first. Three other states indicated a desire for Medicaid to be first dollar but coordination with other health

programs was poor and hence billing from them was sporadic.

This relates to the problems of equivalent care discussed under screening. All but two states are very concerned about using Medicaid dollars to free up categorical funds to expand services to the marginally non-eligible populations. Currently, however, the state of records and accounting permit no estimates to be made of categorical dollars that could be billed to Medicaid.

SUMMARY

Costs of EPSDT, with the exception of screening, are difficult if not impossible to determine. Administrative costs are submerged in other budgets making it difficult to assess without establishing appropriate cost accounting systems.

The biggest difficulty lies in determining D&T costs because of the lack of intergation of screening and D&T files. This problem makes it difficult if not impossible to separate D&T costs resulting form screening from those which result from "episodic" encounters.

Finally it should be noted that the use of Medicaid as first health dollar is not always the rule. As a result, this has increased the difficulty of intergrating other Federal financed health program servicing children into the EPSDT structure.

4.2.3 PROVIDER AGREEMENTS

Provider participation in EPSDT is critical. Few states have sufficient public medical resources to provide screenings, and none can provide all of the treatments covered under their State Medicaid Plans. Hence a variety of methods have evolved to attract providers into servicing EPSDT.

Most states separate enrollment for screening vendors from enrollment for diagnosis and treatment. Accordingly, these two processes will be considered independently.

SCREENING

Three states which use county health departments for medical or dental screening merely extend the agreements between state health and welfare departments to service EPSDT. One state, which relies almost entirely on solo practitioners, does not have proprietary contracts. Instead, each signed bill submitted represents a unique and separate agreement.

Four states which use a broad mix of vendors to provide screening employ varying enrollment methods. Three states use formal agreements: in one state between the Title XIX agency and the provider; in the other two states between the health department and the provider. One state supervised program enrolls through the health department using eligibility standards.

The eligibility requirement for screening is approximately the same from state to state: license to practice medicine in the state. Clinics are subject to a more rigorous process often entailing site visits and extended questionnaries to determine clinic capabilities. This process obtains for local health departments, Title V agencies and NHC's. One state requires all screening providers to prove that licensed medical facilities have agreed to accept referrals from the screening vendors.

DIAGNOSIS AND TREATMENT

Enrollment of providers for D&T services is usually separate from that of screening. In at least three states, all eligible to perform diagnosis and treatment may screen, but not all screeners may perform diagnosis and treatment. One state uses its health department to provide a major protion of diagnosis and treatment except for dental service which is provided by private practitioners. This functions through formal contracts between the health and welfare departments at the state level. In one state, a private fiscal intermediary handles enrollment. In three states, any licensed provider may submit bills for diagnosis and treatment.

The contracts are typical of Title XIX and are written to preclude fraud rather than to specify type or quality of service. Review procedures, reporting requirements, and vendor freedom of choice are essential parts of the contracts.

Diagnosis and treatment record requirements are generally more detailed than for screening records - the number of disorders possible, for instance, guarantees the use of a complicated set of codes. The billing records are the primary source of client medical information at the state level. Only two states can provide on a routine basis a cumulative record by patient of all claims tendered via Medicaid. Other states are working toward this capability.

VENDOR IDENTIFICATION NUMBERS

Vendor identification numbers are assigned separately for Medicaid diagnosis, treatment and screening in one state. Another state uses the provider's Social Security number, two others use the state license number, and other states assign numbers serially. One state has two parallel series of numbers, one for medical providers, one for dentists. Thus, two providers may have the same number, and only a determination of which service type was provided identifies the type of provider.

All states maintain computerized vendor files to check eligibility and to assist in UR.

SUMMARY

Despite the ease of enrollment, states indicate that provider availibility continues to be the main problem in implementing EPSDT. It might be interesting to analyse both screening and D&T data as a function of providers

to determine the extent to which provider availability has hampered program implementation.

Finally, it should be noted that as economic conditions continue to decline changes may occur. While it is true that financial incentives in terms of amounts have not seemed to increase participation, the very fact that Title XIX is able to pay rapidly in some states may become an incentive which will result in changes in provider service patterns where EPSDT eligible populations are concerned.

4.2.4 CLIENT ENROLLMENT

The first services performed under EPSDT are those necessary to enroll clients: identifying eligibles; notifying eligibles; scheduling appointments; providing supportive services; and re-scheduling for broken appointments. The compliance mandates specify that each eligible case be notified at least once annually in writing of the availability of EPSDT services and that transportation be provided for those in need. Beyond that, the states are essentially left to their own methods of linking the eligible population to screening services.

ELIGIBILITY

Eligible populations are clearly defined in the State Medicaid Plans, but the problem of locating those eligible children in need of EPSDT is more complex. Those children enrolled in categorical aid programs are readily identifiable through case lists. A more subtle problem is locating those

children eligible as medically needy under the state plan. This issue is not yet being vigorously pursued in the states concerned, mainly because of the priority assigned to AFDC recipients.

A severe complication arises in targeting specific eligible sub-populations for EPSDT activities. The importance of this issue cannot be overemphasized when considering the longitudinal delivery of child preventive health services. Large but indeterminate portions of Medicaid eligible children are already receiving some form of medical services through Title V programs, state school health programs, state public health programs, other Federal categorical programs, and private providers. Of the states visited by Bokonon, only one has seriously addressed the question of equivalent services outside the structure of EPSDT.

Yet this targeting is critical to the efficient operation of an EPSDT effort, particularly to the process of allocating scarce resources and minimizing cost. If children already under some form of health care receive screening services, the opportunity cost is high. Not only has effort and expense been duplicated but likely to detriment of one not receiving care. In an environment of scarce availabilities, this is an especially ineffieient use of resources. Thus, the current absence of a refined technique for breaking out sub-populations of unserved children from the gross eligibility files represents a most significant barrier to delivering EPSDT health services and of planning for future resource needs and allocations. locations.

The gross eligibility pools for EPSDT are, in all states, compiled by the regular eligibility determination offices of the state welfare departments. In state administered-locally supervised Medicaid Plans, the eligibility files are centralized and computerized at the state level. At least annually, the states produce master lists of eligible cases. These lists, however, are updated monthly, weekly, or in two cases, daily. These central files are helpful in tracing transient cases through time, a capability discussed later. Eligibility lists are provided to local social service workers by the state social service agency in two states. The state social service agency provides local health departments with current eligibility lists in three states. Local or district offices product their own lists in three states.

OUTREACH

Translating the gross eligibility pool into an effective outreach effort varies from state to state. The outreach responsibilities primarily fall to social service workers at the local level, although two states coordinate heavily with the screening providers (the local departments of health). Where there are several public and private screening providers, this coordination does not exist except in relation to broken appointments (no-shows).

All visited states rely upon the certification or recertification interview to inform the clients of service benefits and procedures. Thus,

a client may well be aware of EPSDT services prior to formal enrollment into the eligibility pool. Home visits by social service workers in two states supplement the interview information. Two states take the opportunity of the certification interview to determine whether or not the eligibles under 21 are receiving equivalent screening care. This is a potentially significant cue for sorting eligibles for more intensive outreach efforts. One local site uses public health nurses to perform outreach through home visits.

Written mailers are generally regarded as ineffective as outreach materials relative to personal contacts. All states comply with Federal Regulations: notices are sent on an annual or bi-annual basis. Written materials are also available at various social service agencies. These brochures and leaflets contain information about what EPSDT services are available and how to obtain them. Four states have used the media to inform eligibles, mainly through interviews or feature stories in local papers or by producing spots aired as public service announcements.

There is no concensus among the states about the effectiveness of outreach. There is an intuitive feeling on the part of many state officials that personal contact generates the highest return. But it becomes extremely difficult to link outreach procedures and outreach effectiveness because of the breadth of differences that exist from state to state on scheduling procedures.

SCHEDULING

Scheduling activities vary greatly from state to state. One state informs eligibles when they are scheduled for screening, three others provide a list of three providers to each family and the family is primarily responsible for scheduling with screening providers. The remaining four states place primary responsibility for scheduling with the social service worker.

In any state, however, a family may seek a screening appointment on its own initiative, either directly with the provider or through the caseworker.

NO-SHOWS

Formal responsibility for rescheduling no-shows lies with the social service caseworker in all states, although in three this function overlaps with specific screening providers, i.e., local health departments. The case worker is notified by the provider of the broken appointment. One state overschedules its health clinics to assure maximum utilization of facilities. Two states admit that rescheduling is an informal system, left to the discression and agression of the caseworker and the provider.

It is interesting to note that one state has sub-contracted all outreach services in a major metropolitan area to a local welfare reform organization.

The contract has not been in effect long enough to determine the effectiveness of this process but the state is hopeful of increasing the penetration rate through this method.

PERIODICITY

Periodicity has been officially implemented in only one state: quotas have been set by county. In other states, periodicity is in effect only to the extent that eligibles themselves request re-screening. This is because initial screenings have not been completed on the total eligible population. At least two other states plan to implement periodicity plans, but not for fiscal 1975. All states have a recommended periodicity schedule but one state allows the screening vendor to set periodicity as needed by an individual client.

Determining the penetration rate of these outreach activities has been very unsuccessful to date. Only one state includes equivalent care in its reported total screened for the OPM Quarterly Reports. One state believes that EPSDT merely formalizes a system of provision of care to the poor that has existed since the state was founded. The question of equivalent care receives varying answers state to state. One state includes all Title V enrollees as receiving equivalent care, another excludes all Title V as being inadequate. The enormous number of health care dollars and programs available to the poor are obscured by programs such as vision and hearing screening that are available to all children in a state.

Currently, no state is fully confident that the number of eligibles across time can be fixed, or that equivalent care issues can be resolved. The improvements forthcoming in automated records and unified files may ease this condition, but there are no easy solutions to determine the penetration rate. Yet this measure is clearly of paramount importance in program evaluation.

SUPPORT SERVICES

Support services are the responsibility of the local social service workers in all states. The most common services provided are transportation and day care for children. As mentioned, one state has sub-contracted all transportation to the state OEO for all social services, with EPSDT the primary priority. Two states require prior authorization if transportation costs any money; another one provides funds as part of the cash welfare grant. All states emphasize that wherever possible, family or voluntary agencies provide services, this in line with a welfare philosophy that stresses minimizing client dependency on public agencies.

4.2.5 SCREENING

The primary EPSDT thrust at present is directed toward screening. The reasons for this hinge upon the delays in initiating the program coupled with recent Federal and legal pressures. It is interesting to note, however, that despite the pressures states have implemented screening in ways which typically reflect their past history in health delivery. These methods range from exclusive use of solo providers to increasing capabilities

of local public health programs.

In this section we attempt to review screening efforts with particular attention to providers, data files and the uses of the information gathered.

PROVIDERS

Three states rely entirely on local public health departments for medical screening which reflects the prominent position public health has occupied in those states for several decades. Four states use public health clinics when available, and one state relies almost entirely on solo practitioners. The four which use some local public health agencies also use clinics, school health programs, Title V programs, HMO's, and private practitioners.

Dental screening is by-passed in one state (all children are sent directly to D & T), another uses public health dentists and six use private dentists.

Most states complete screenings in one visit except when special tests are needed. One state has a vision and hearing screening program for all children, so that three separate screenings are needed: vision and hearing, medical and dental.

Provider availability (enrolled providers) was cited as a major problem in one state and all states noted difficulties in rural areas. In addition all states indicated a shortage of dental providers.

In one state mobile units for both medical and dental screening were in operation and further expansion was being considered to meet rural needs. In another state dental service was being expanded by the use of mobile units.

While some states were considering transportation alternatives, all were closely watching the use of mobile units as a solution to the problem of screening.

States have attempted to use financial incentives to increase provider participation. This has taken two forms: generous flat fee for screening and rapid payment.

Despite these efforts no data is available which indicates the effects of financial incentives upon provider participation. It is possible, however, that during these trying economic times, high reimbursement rates and rapid payment may lead to increased provider participation. It is important that if this occurs a close watch on utilization patterns of former users is maintained to determine if the incentives are serving to withhold medical care from these other populations.

SCREENING PACKAGES

The screening packages were similar in the states visited with Federal guidelines setting standards. In general differences reflected local emphasis rather than content: testing for lead poisoning in older urban areas; sickle cell testing for blacks, etc.

The major differences between the states lie in the use of personnel involved in screening and their level of activity. While most states rely on non-providers for patient history these may range from nurse practitioners to specially trained para-professionals. Much discussion was found concerning the allocation of screening activities to non-medical personnel although no general theme could be ascertained.

USE OF OTHER HEALTH PROGRAMS

Screening children does not operate exclusively through Title XIX. Title V and state health programs preceeded EPSDT by many years. However, coordination between EPSDT and the range of child health programs is somewhat restricted in the states. Federal policy makes it impossible for school districts to be reimbursed from Title XIX funds for services otherwise rendered free of charge. The wide range of Title V efforts means that equivalency determination by the enrollment agencies occurs generally on a case by case basis. On the other hand, preventive programs such as PKU testing, vision and hearing screening, and immunization programs are easier to incorporate into the EPSDT process.

Nonetheless, the state EPSDT programs are not confident of their relationship to other programs. The reasons are many: conflicting administrative domains; ambiguous regulations; lack of file interfaces; and political factors. The mandate for EPSDT clearly implies coordination with existing services, but, the nascent EPSDT effort has not formally chosen

between the poles of coordination and programmatic service delivery.

DATA FILES

Screening records are of mixed quality and availability. Three states use a billing form that contains only a procedure code to discriminate between an initial screen and a periodicity check. Four states use a billing form that records procedures performed during screening. However, only one state computerizes all the procedures performed.

A client's screening record generally remains within the domain of the provider. Even where the screening procedures are detailed, the degree of abstraction that occurs in the computerization of data makes analysis and aggregation of information difficult. There is also the problem of split files, i.e. part of the client history remains in the case file, part in the screening form, and part in the billing file.

Despite the problems and with the exception of the three states which only code screening as an encounter, screening information is available and accessable. Even the three states have hard copy of screening events stored. Increased file unification and more thorough computerization of records (processes in progress in every state) should reduce the difficulty of ascertaining screening procedures and outcomes.

EVALUATION

The evaluation of screening is mysterious territory to most states. All states have utilization review as required in state plans, with medical units assigned to perform the task.

The means of performing evaluation depend upon the type of screening providers used in a state. Five states who use some form of clinic for some or all screenings conduct site visits of clinics to check for adequacy of the facility, record keeping, etc. All states check for fraud, over utilization, bizarre billing patterns and duplicate claims.

No one is satisfied with the means of evaluation available, especially as regards solo practitioners. The sad fact is that the heart of EPSDT - the early screening of children - remains without an acceptable and successful means of evaluating the quality of service.

Equally unknown to date are false negative and false positive rates of referral from screening. If treatment can be tied to screening referrals, the latter problem is resolved. As for the former - no one has been able to offer a solution short of re-screening. But this raises the issue of cumulative error rates, and no state has found a means of determining this figure.

4.2.6 DIAGNOSIS AND TREATMENT

The intent of the EPSDT legislation is obtained when and if screening identifies health problems which in turn are confirmed through diagnosis and subsequently receive treatment. The impact or success of the program lies in an ability to show that early detection of morbidity (for which there is treatment) and its treatment leads to decreases in long term debilitating chronic illnesses.

The program has not been in existance long enough to examine its impact. However, D & T can be considered in terms of efforts which by definition are required for EPSDT. These are:

- D & T interface with screening.
- Provider availability.
- Data files.
- Evaluation of D & T.

DIAGNOSIS AND TREATMENT INTERFACE

The linkages between screening and diagnosis and treatment within the states leaves much to be desired. With the exception of those states where screening, diagnosis and treatment can occur simultaneously who receives diagnosis and treatment after screening cannot be determined. This is further compounded by children who do receive treatment during screening for which no bill or report is prepared (one state estimated that fully one-third of those who were screened received some form of treatment

during screening which was not reported).

Those states where screening and diagnosis and treatment function separately have the most problems. The present approach is to attempt to match positive screening profiles with D & T claims which are billed in the next ninety days. This method is filled with pitfalls: some public and private providers are as far as six months behind in billings; the billing forms are not specific enough to discriminate an "episodic" encounter from a referral etc.

One state has obtained a partial solution to this problem by requiring a treatment plan except in emergencies to be submitted for approval. However, this has been accompanied by minor treatments being performed without being recorded and by an apparent increase in "emergency" treatment.

Only one state requires a treatment claim to indicate that it resulted from an EPSDT referral.

Case workers appear to function effectively through screening but, their efforts in referral through D & T appear limited.

Accordingly, it can be concluded that the data describing EPSDT D & T is fragmentary and inaccurate.

PROVIDERS

D & T provider participation suffers from problems similar to those in screening: limited participation; shortages in rural areas; and a general shortage of dentists.

D & T is provided on the most part by solo providers under regular Title XIX rules. Additional service is obtained through the use of Title V programs (mostly well baby and Child and Youth projects) and by state categorical health programs such as: T.B.; V.D.; lead poisoning, etc. Six of the eight states have one or more such programs in operation.

Those states which have histories of strong public health programs are attempting to expand services by increasing public health capabilities. We found increased use of mobile health delivery units, particularly dental, in both rural and urban areas.

In states where sole practitioners offer most of the service financial incentives are in use or planned to increase participation. In the main these consist of improving payment time lag by insuring rapid payment. While this does not appear to have had a major effect to date it is entirely possible that as general economic conditions worsen, this will serve to increase participation.

EVALUATION

Evaluation of diagnosis and treatment like that of screening is limited and

reflects the state of the art. In the main efforts are directed to Utilization Review processes and are most effective in limiting fraud. These activities typically: review high volume vendors; respond to recipient complaints; consider questionable bills; and respond to other professional complaints.

In addition, several states have initiated prior treatment authorization plans to limit excessive payments. These plans are also reviewed for adequacy of proposed treatment and so serve as a possible quality control.

One state uses two methods of evaluating dental care. First, a child dental profile is being added to the client record to verify the need for treatment for a given tooth. If the tooth was removed, it clearly is not in need of a filling, etc. In the second method, a mobile unit is beginning to visit areas of the state to check the teeth of all children in an area for whom a bill was submitted in order to verify that the specified treatment was actually performed.

In addition to these efforts, almost all states which use clinics had a unit which periodically carried out site visits to observe clinic functions. These programs serve as quality control only in the most rudimentary terms.

No state appeared to have a long range approach to the use of D & T data for evaluation. Nor was any state considering the relationship of treat-

ment to outcome as a possible measure of the impact of EPSDT.

DATA FILES

The quality of D & T data files varied widely. Examination of the flow charts and the State Data File Matrix (appendix B) provides a detailed description of what is presently in place.

While continuity of data between screening, diagnosis and treatment is the most prevelant problem (note section on screening, and diagnosis and treatment linkages) the most serious one is that resulting from the controversy surrounding the use of procedure codes. While it is recognized that without proceedure codes no real analysis of D & T can take place, arguments continue concerning which coding system to use, to what level of detail, etc.

We found one state using three codes, others which had prepared their own and a general lack of consensus about which to use. Moreover one state reported that despite having medical society approval for the code finally selected over 70% of treatment billings were listed outside the codes as "other".

One final note, since all states have extensive UR procedures, most of the data presently stored is accurate and up to date.

4.2.7 CASE MANAGEMENT

In addition to specifying health care requirements, the uniqueness of EPSDT as a Title XIX program is indicated by guidelines which specify case finding activities. Not only is a level of health service delivery specified, but case management activities to insure health delivery are also detailed. Accordingly, operational responsibility for assuring client-EPSDT activities has become the charge of social service caseworker.

State EPSDT objectives intimately involve case workers. Screening and periodicity quotas, reduction of no-shows, follow-up on screening referrals, and rapid screening of the newly eligible are all dependent upon the quality of case management. Thus, there is pressure within several states to allocate specific employees to EPSDT activities. Currently, only one state visited employs case workers specifically for EPSDT. This initiative runs counter to another tendency in the states, that of reducing expenditures for welfare. Accordingly, most states have added EPSDT activities to the caseworker's present job responsibilities. This cross-current operates to the detriment of EPSDT in general and case management personnel suffer the brunt of this imposition.

An essential long range objective of EPSDT is to alter the utilization patterns of the client population from episodic to preventive care. Health education and nutrition programs are under consideration in several states toward this end, and integration of similar programs

that already operate is a distant objective. The personnel tagged to perform educational services not currently available under existing programs are the caseworkers. Since the ultimate success of EPSDT depends in no small part upon the patterns developed by the eligible population (self-scheduling, for instance) these programs are of great consequence to the future of EPSDT.

State efforts in case management were found to function in one of two ways: continuous or segmented. In the former, a particular caseworker maintains supervision and responsibility throughout all stages of a client's progress through EPSDT. The latter is obtained by segmenting responsibility among several agencies or individuals according to which portion of the EPSDT process the client is negotiating.

The following sections discuss case management activities observed during the site visits.

ENROLLMENT

Generally, eligibility was found to be determined by special certification employees or by regular social service workers, although in one state, both initial and re-certification were the responsibility of a separate agency.

Social service workers continue their involvement and are responsible for notifying and scheduling eligibles for screening. This entails a broad variety of activities:

Identification of eligibles

Notification of eligibles

Scheduling appointments

Provision of supportive services

Re-scheduling for broken appointments.

Each of these functions has been detailed as to procedure and responsibility under 2.2.4, Client Enrollment. However, it is important to note that even in those states where case management is segmented, the social service worker still maintains a level of responsibility since EPSDT is among client services.

Since the target population has generally had little or no experience with health delivery systems, the quality of guidance rendered by case workers is critical to client enrollment and participation in EPSDT. The degree of case management responsiveness to client needs is a major determinant of EPSDT penetration rate.

SCREENING - DIAGNOSIS & TREATMENT LINKAGE

The single most important effort among the case manager's activities is to insure that children referred for an abnormality receive diagnosis and treatment. Although two states require the screening vendor to perform

this service, the remaining six states list this as an activity of the social service worker. In addition, as part of their regular on-going casework effort, the social workers are required to arrange for subsidiary services such as transportation and day care as well as to be responsible for the paper-load required by these services.

No matter who is responsible for insuring the linkage among screening, diagnosis and treatment, cooperation between screening vendors, case workers and diagnosis and treatment vendors is necessary. The linkage between the case worker and diagnosis and treatment vendors becomes even more important in those cases where treatment requires a series of visits.

To aid the caseworker in determining which children require referral to diagnosis and treatment and to insure that D & T takes place, one state attempts to provide the caseworker with an indication of the screening referral and subsequently to indicate whether or not a bill has been submitted for treatment of that client. This match of the D & T payment files with screening referrals is being considered particularly in those states which presently maintain separate screening and D & T files.

TRACKING

Client tracking is a major concern in all states. Procedures for referral are present in all states, however, use is voluntary in most states and the results are reported and stored into a data system in only one state.

Two states specifically reported that they lacked the authority with which to require local offices to maintain referral procedures and forms. However, every state has an adequate case or client identifier with which to track an individual through the various files - the client identification code. Thus, the means for automated queing and tracking exist in all states, but was not in use in most states visisted (seven).

PERIODICITY

Periodicity management is distributed variously. All states have established periodicity schedules, although one state allows the screening provider to establish periodicity on a case by case basis. One state presently is undertaking rescreens according to their periodicity schedule with the state responsible for client identification. In the other states (7), periodicity is essentially left to client initiative, caseworker initiative, or provider initiative - a very personal system. Ultimate responsibility lies with the notification and scheduling agency with one exception - one state makes periodicity the responsibility of the screening provider following the initial assessment.

SUMMARY

It was clear from our visits that institutional or personal style of case management does determine the level of success of EPSDT efforts. Caseworkers in both welfare and public health departments have enormous personal latitude in carrying out activities necessary to channel children

into EPSDT and shepherd them through the entire cycle. It would seem that the passivity or aggressiveness of case management can transcend any structural limitations, perhaps more so than any other component within EPSDT.

The major problem faced by the case manager in carrying out efforts lies in the lack of an organized file system which would permit appropriate tracking of client status. In one state, we observed the rudimentary development of an on-line client information system which permits caseworkers to call up client data through the use of remote terminals. Clearly, such a system would maximize EPSDT efforts by making clear the status of EPSDT eligibles on a client by client basis as opposed to gross totals typically reported by states.

APPENDIX A
STATE AND LOCAL QUESTIONNAIRES

STATE QUESTIONNAIRE

OBJECTIVES

What are the state's objectives for EPSDT for this year, for this quarter?

What does full implementation mean to you?

When do you expect to be fully implemented?

Who is pressing for full implementation of EPSDT?

Are there people opposed, who?

Who is responsible for evaluation of objectives?

How is this done?

May we have copies of planning and policy documents which identify your objectives; for example do you prepare a proposal each year?

Documentation: Planning, and policy documents.

STATE EPSDT ROLE

What are the responsibilities of the state agency for monitoring EPSDT implementation?

May we have copies of the relevant guidelines?

How are local efforts evaluated:

- outreach
- screening
- diagnosis and treatment
- follow-up?

What authority does the state agency have to order alterations in local efforts?

How does EPSDT relate to Medicaid?

Is EPSDT a separate administrative unit?

What is the role of EPSDT in the state Medicaid plan?

Documentation: State Medicaid plan
EPSDT guidelines and authority.

INTERAGENCY RELATIONSHIP

Do you have any relationships with other programs which provide medical services for children?

Are these formal, if so, do you have copies of the formal arrangements?

Documentation: Formal agreements.

OUTREACH

Do you have a plan for identifying eligibles, what is it?

Are you responsible for notification? If yes, how do you do it?

SCREENING PROCEDURES

How many have received a complete screening to date?

What are the components of a screening?

Who establishes that?

Who establishes the periodicity schedule?

May we have copies of the periodicity schedule?

Documentation: Screening manual and referral standards
Incidence data.

SCREENING EVALUATION

Who evaluates adherence to screening standards?

How is this done?

Is there any means of establishing a false positive rate? False negative rate?

May we have copies of any evaluation designs used or being planned?

Documentation: Screening standards and procedures manual
Evaluation designs

DIAGNOSIS AND TREATMENT

What standards for treatment exist?

Who establishes these standards? How is treatment reviewed for quality?

How is diagnosis and treatment billed?

Can client progress through treatment be tracked by the billing system?

How are specific diagnoses recorded?

Is the billing system used to provide feedback to case managers on client progress? How?

Documentation: Standards and procedures manual
PSRO plan, etc.

DATA SYSTEMS

What is the system for processing EPSDT data?

Is there a centralized state data system? Is one planned?

If not, how are state data collected?

What reports have been derived from available data?

May we have copies of these reports?

How long before client data are entered into your data system?

Are EPSDT records maintained separately from the regular Medicaid files?

Is there anything on a Medicaid record to indicate client participation in EPSDT?

What happens to client data during periods of Medicaid ineligibility?

What systems exist to check the accuracy of recorded data?

What links exist between information system and the case management?

Documentation: All data forms used transmit data on clients including screening outcomes and billing, and systems manuals for either computer or hard copy system. Computer specification including program source and sample output.

COST DATA

What is the total number of state personnel assigned to EPSDT?

What is the total budget?

May we have copies of your budget?

Documentation: Budgets.

May we have a copy of this year's Medicaid budget?

Is EPSDT a distinct part of Medicaid budget?

Where are the total resources available for EPSDT including state appropriations, local appropriations, volunteer time, and overlaps with pre-existing children and youth programs?

How much has EPSDT added to existing social service administration costs?

How much does a single screening cost, including outreach screening, and case management?

What data are available on cost effectiveness? May we have any documentation on cost effectiveness studies?

How much do cost considerations impede implementation?

What would full implementation of EPSDT cost?

Documentation: Budget for Medicaid and EPSDT
Cost agreements with other agencies
Cost effectiveness procedures and studies
Fee schedules
Procedures for reimbursement.

PROVIDER AGREEMENTS

How many providers are enrolled for EPSDT screening services?

How many do you need for full implementation?

Do you have any cooperative arrangements with the state Medical Society or any other medical society, may we have copies of these agreements?

Is there any physician resistance to participation in EPSDT?

What are the reasons for this?

Documentation: Provider agreements with the EPSDT agencies
Medical Society agreements with EPSDT agencies

CASE MANAGEMENT

What agency is responsible for case management?

If more than one agency is responsible for case management what are the divisions of responsibility?

May we have copies of any guidelines or inter-agency agreements pertaining to this?

What agency is the repository for client records?

Documentation: Case worker guidelines
Interagency agreements
Client forms.

LOCAL PROJECT QUESTIONNAIRE

OBJECTIVES

What are your objectives for EPSDT for this year, for this quarter?

What does full implementation mean to you?

When do you expect to be fully implemented?

Who is pressing for full implementation of EPSDT?

Are there people opposed, who and why?

Who is responsible for evaluation of objectives?

How is this done?

May we have copies of planning and policy documents which identify your objectives, for example do you prepare a proposal each year?

Documentation: Planning, and policy documents.

ORGANIZATIONAL ROLES

Who is responsible for EPSDT activities?

Do you have functional descriptions of all staff members, may we have copies of these descriptions?

Documentation: Staff descriptions.

INTER-AGENCY RELATIONSHIPS

Do you have any relationships with other local children and youth programs?

Do you have any relationships with other programs which provide medical services?

Are these formal, if so, do you have copies of the formal arrangements?

If yourarrangements with other children and youth projects are informal could you please describe them?

Documentation: Formal agreements

OUTREACH

What processes do you use to identify eligibles?

How often do you upgrade this process?

Are there any sub-populations selected for intensive outreach? Which are they?

Who notifies eligibles?

What means are used to notify them? May we have copies of any written materials or notification guidelines?

What assures that eligibles receive some form of notification?

How are enrollees in other child programs included in the notification process?

What problems remain in notifying eligibles?

What percentage of total eligibles have been notified?

What percent have expressed an interest in being screened?

Documentation: outreach material
state mandate
guidelines
procedures
staff assignment.

SCHEDULING

Who is responsible for making appointments for screening?

How many no-shows for appointments have occurred?

What are the procedures for following up broken appointments?

May we have copies of any guidelines describing any of these procedures?

Documentation: Instructions to appointment makes including no-show procedures and statistics on appointments made, no-shows and target quotas.

SCREENING PROCEDURES

How many have received a complete screening to date?

How many screenings a day are being done?

What are the components of a screening?

How many screenings a day can be done?

How long does a complete screening take?

Who determines that?

May we have copies of the screening and referral standards manual, registration forms, medical records, reimbursement forms, referral forms, and permission forms, as well as instructions on their proper routing?

To what providers are positives referred?

Are screening and diagnosis occurring simultaneously?

Who establishes the periodicity schedule?

May we have copies of the periodicity schedule?

Documentation: Screening manual and referral standards
Clinic forms detailed above
Incidence data.

SCREENING EVALUATION

Who evaluates adherence to screening standards?

How is this done?

May we have copies of any documents or guidelines pertaining to UR or PSRO?

Is there any means of establishing a false positive rate? Flase negative rate?

Are clients records used to evaluate screening?

How is this done?

Who does it?

May we have copies of any evaluation designs used or being planned?

Documentation: Screening standards and procedures manaul
Evaluation designs.

DIAGNOSIS AND TREATMENT

What is the lag time between a positive screening and an appointment for diagnosis?

Does treatment begin at the same time diagnosis occurs?

Is parental permission necessary prior to treatment?

Is agency permission necessary prior to treatment?

What standards for treatment exist?

Who establishes these standards? How is treatment reviewed for quality?

Documentation: Standards and procedures manual
PSRO Plan, etc.

DATA SYSTEMS

What is the system for processing EPSDT data?

What reports have been derived from available data?

May we have copies of these reports?

How long before client data are entered into your data system?

Are EPSDT records maintained separately from the regular Medicaid files?

Is there anyting on a Medicaid record to indicate client participation in EPSDT?

How does the system operate to identify clients whose time for a health assessment has come again?

What happens to client data during periods of Medicaid ineligibility?

What systems exist to check the accuracy of recorded data?

What links exist between information system and the case management?

Documentation: All data forms used to transmit data on clients including screening outcomes and billing, and systems manuals for either computer or hard copy system.
Computer specification including program source and sample output.

COST DATA

What is the total number of staff assigned to EPSDT?

What is the total budget?

May we have copies of your budget?

Documentation: Budgets.

What are the total resources available for EPSDT including state appropriations local appropriations, volunteer time, overlaps with pre-existing children and youth programs?

How much is budgeted for outreach?

What are the costs of notification per client?

How much of the EPSDT budget is for non-medical services?

Are diagnosis and treatment costs charged to EPSDT or Medicaid?

What are the other budgetary sources for EPSDT funds?

How much is a single screening cost, including outreach, screening, and case management?

What are the costs of treatment by disease category?

What data are available on cost effectiveness?

May we have any documentation on cost effectiveness studies?

How much do cost considerations impede implementation?

What would full implementation of EPSDT cost?

Documentation: Budget for Medicaid and EPSDT
Cost agreements with other agencies
Cost effectiveness procedures and studies
Fee schedules
Procedures for reimbursement.

PROVIDER AGREEMENTS

How many providers are available to you for EPSDT services?

How many do you need for full implementation?

Do you have any cooperative arrangements with the Medical Society, or any other medical service, may we have copies of these agreements?

Is there any physician resistance to participation in EPSDT?

What are the reasons for this?

Documentation: Provider agreements with the EPSDT agencies
Medical Society agreements with EPSDT agencies.

CASE MANAGEMENT

Who is responsible for monitoring the client through EPSDT?

Is case management continuous or segmented?

If more than one individual or an agency is responsible for case management what are the divisions of responsibility?

May we have copies of any guidelines or inter-agency agreements pertaining to this?

What agency is the repository for client records?

Documentation: Case worker guidelines
Inter-agency agreements
Client forms.

APPENDIX B
STATE DATA FILE MATRIX

KEY

STATES

FL = FLORIDA
IL = ILLINOIS
LA = LOUISIANA
N.O. = NEW ORLEANS
OK = OKLAHOMA
SC = SOUTH CAROLINA
WA = WASHINGTON

TECHNICAL

C = COMPUTER FILE
DT = DISPLAY TERMINAL
HC = HARDCOPY AND/OR MICROFILM
SC = SINGLE CODE STORED ON COMPUTER FILE
SV = ONLY SOME VARIABLES STORED ON COMPUTER FILE
BC = BLUE CROSS/BLUE SHIELD

STATE DATA FILE MATRIX

FILE	STATES						
	FL	IL	LA	N.O.	OK	SC	WA
I. ELIGIBILITY FILE.	C	C	C	C	C	C	C
II. VENDORS FOR SCREENING FILE.	HC	C	C	C	C	HC	C
- PROCEDURES LINKED WITH AMOUNTS.	C	C	C	C	C	C	C
III. VENDORS FOR TREATMENT FILE.	C	C	C	LA	C	BC	C
- PROCEDURES LINKED WITH AMOUNTS.	C	C	C	LA	C	C	C
IV. PROCEDURE CODES & REIMBURSEMENT FEES.	HC	HC	HC	LA	C	HC	HC
V. PRE-AUTHORIZED REQUESTS.	C		HC	LA	HC	C	HC
VI. MEDICAL PROFILE.*	DT-SV	C		C		C	
A. FAMILY HISTORY	HC	C	HC	C	C	HC	HC
B. MEDICAL PROFILE = SCREENINGS + TREATMENTS.					C	SV	
C. SEPARATE RECORD FOR EACH SCREENING.	HC	C	HC	C	C	HC	HC
D. SCREENING RECORD INCLUDES.	C	C	C	C	C	C	C
1. PROCEDURES PERFORMED.	DT-SC	C	C	C	C	C	SC
2. REFERRALS.	DT	C	C	C	C	C	HC
3. DENTAL RESULTS.		C		C			
4. VISION/HEARING RESULTS.		C		C			
5. MEDICAL HISTORY + IMMUNIZATIONS.		C		C	HC		
E. SEPARATE RECORD FOR EACH TREATMENT.	C	C	HC	LA	C	HC	C
F. TREATMENT RECORD INCLUDES.	C	C	C	LA	C	C	C
1. REFERRAL FROM.							
2. PROCEDURES PERFORMED.	C	C	C	LA	C	C	C
3. OUTCOME.							
G. FLAG FOR SCREENING.	DT			C			
H. FLAG FOR FOLLOW-UP.	DT	C		C	C	C	HC

* A THROUGH H VARIABLES MAY NOT BE ON THE SAME FILE NOR ON THE SAME HARDCOPY RECORD.

APPENDIX C
STATE EPSDT COMPONENT MATRIX

KEY

STATES

FL = FLORIDA
IL = ILLINOIS
LA = LOUISIANA
N.O. = NEW ORLEANS
OK = OKLAHOMA
SC = SOUTH CAROLINA
WA = WASHINGTON

COMPONENTS

BC = BLUE CROSS/BLUE SHIELD
CP = CERTAIN PROCEDURES
DR = IF DIRECTLY REFERRED
M = MEDICAID
PHU = PUBLIC HEALTH UNITS
R = REVIEW ONLY
WL = WHICHEVER IS LESS
FA = FISCAL AGENT
NC = NO CHARGE TO TITLE XIX

STATE EPSDT COMPONENT MATRIX

	STATES						
	FL	IL	LA	N.O.	OK	SC	WA
I. TITLE XIX AGENCY.							
A. SINGLE STATE AGENCY.	YES	YES	NO	NO	NO	YES	YES
B. UMBRELLA AGENCY.	NO	NO	YES	YES	YES	NO	NO
II. ELIGIBILITY IDENTIFICATION.							
A. CROSS-REFERENCE WITH PAST ELIGIBILITY.	YES	NO	YES	YES	YES	NO	YES
B. USED AS SCREENING ID.	YES	YES	YES	YES	YES	YES	YES
C. USED AS DIAGNOSIS & TREATMENT ID.	YES	YES	YES	YES	YES	YES	YES
D. HARDCOPY REFERENCE FOR PROVIDERS.	PHU	PHU	PHU	PHU	NO	YES	NO
E. DISPLAY TERMINAL REFERENCE.	YES	NO	NO	NO	YES	NO	NO
F. ID CARD TO PRESENT TO PROVIDER.	YES	YES	YES	YES	NO	YES	YES
III. FORMAL AGREEMENTS.							
A. MEDICAL SCREENING.	NO	YES	YES	YES	NO	YES	YES
B. DENTAL SCREENING.	NO	YES	NO	YES	NO	NO	YES
C. MEDICAL TREATMENT.	M	M	NO	NO	NO	NO	YES
D. DENTAL TREATMENT.	M	M	NO	NO	NO	NO	YES
IV. VENDORS FOR SCREENING.							
A. SOLO PRACTITIONERS.	NO	YES	NO	NO	YES	NO	YES
B. PUBLIC HEALTH UNITS.	YES	YES	YES	YES	FEW	YES	YES
C. PRIVATE DENTISTS.	NO	YES	NO	NO	YES	NO	YES
D. MOBILE UNITS.	YES	NO	NO	NO	NO	NO	NO
V. VENDORS FOR DIAGNOSIS & TREATMENT.							
A. SOLO PRACTITIONERS.	YES	YES	YES	YES	YES	YES	YES
B. PUBLIC HEALTH UNITS.	NO	YES	YES	YES	FEW	FEW	YES
C. PRIVATE DENTISTS.	YES	YES	YES	DR	YES	YES	YES

	STATES						
	FL	IL	LA	N.O.	OK	SC	WA
VI. REIMBURSEMENTS.							
A. SINGLE STATE AGENCY FOR TOTAL SCREENING PACKAGE.	YES	NO	YES	YES	NO	YES	YES
B.* THIRD PARTY FOR TOTAL SCREENING PACKAGE.	NO	NO	NO	NO	NO	NO	NO
C.* THIRD PARTY FOR DENTAL PROCEDURES.	NO	R-FA	NO	NO	NO	BC-FA	FA
D.* THIRD PARTY FOR VISION/HEARING SCREENING.	NO	NC	NO	NO	NO	NO	NO
E.* THIRD PARTY FOR IMMUNIZATIONS.	NO	NO	NO	NO	NC	NO	NO
F. SINGLE STATE AGENCY FOR DIAGNOSIS & TREATMENT.	YES	YES	DR	DR	YES	NO	YES
G.* THIRD PARTY FOR DIAGNOSIS & TREATMENT.	NO	NO	NO	NO	NO	BC-FA	NO
H. SAME AGENCY FOR SCREENING AND DIAGNOSIS & TREATMENT.	YES	NO	NO	NO	YES	NO	YES
I. FIXED COSTS FOR SCREENING.	YES	WL	YES	YES	YES	YES	YES
J. CUSTOMARY FEES FOR SCREENING.	NO	WL	NO	NO	NO	NO	NO
K. FIXED COSTS FOR DIAGNOSIS & TREATMENT.	YES	YES	YES	YES	WL	YES	WL
L. CUSTOMARY FEES FOR DIAGNOSIS & TREATMENT.	NO	NO	NO	NO	WL	NO	WL
M. PRE-AUTHORIZATION FOR SCREENING.	NO	NO	NO	NO	NO	NO	NO
N. PRE-AUTHORIZATION FOR DIAGNOSIS & TREATMENT.	CP	NO	NO	NO	NO	YES	NO
O. PRE-AUTHORIZATION FOR DENTAL PROCEDURES.	CP	CP	CP	CP	CP	YES	CP

* THIRD PARTY = NON-MEDICAID STATE AGENCY OR PRIVATE PAYMENT ORGANIZATION

APPENDIX D

STATE FORMS ON FILE

STATE FORMS

FLORIDA

- SAMPLE HEALTH CLINIC SCREENING APPOINTMENT NOTIFICATION
- INFORMED CONSENT FORM
- SAMPLE EXPLANATION OF TREATMENT PERFORMED OTHER THAN PROCEDURE CODES (OPTIONAL AND NOT UNIFORM)
- REQUEST FOR PAYMENT (BILLING FORM FOR EVERYTHING)
- MONTHLY MEDICAID SCREENING REPORT (FILLED IN BY CLINIC)
- STATE TOTAL OF MONTHLY REPORT

ILLINOIS

- REDETERMINATION OF ELIGIBILITY (FILLED IN BY CASEWORKER)
- MEDICHEK APPLICATION FORM (SCREENING)
- MEDICHEK SCREENING SUMMARY (BILLING AND HISTORY FORM)
- DENTAL SCREENING SUMMARY (BILLING AND HISTORY FORM)
- VISION/HEARING SUMMARY (BILLING AND HISTORY FORM)
- STATEMENT OF OPTICAL GOODS AND SERVICES
- DENTIST STATEMENT

LOUISIANA

- SOCIAL SERVICE CERTIFICATION AND DISPOSITION
- SERVICES RENDERED TO CHILDREN ELIGIBLE FOR EPSDT (SCREENING FORM)
- SOCIAL SERVICE CASE FORM

NEW ORLEANS

- CLINIC ENCOUNTER FORM
- PATIENT REGISTRATION FORM

OKLAHOMA

- SOCIAL SERVICES FORMS K-1 TO K-16 & 17. (WE HAVE COPIES OF K-1-10-11-15-12-5-6-14-2-8-13- 16)
- CASE INFORMATION FORMS A & B
- SOCIAL SERVICE FORM 3 & 4 (OPENING A CASE)
- ADM-36-K PHYSICIAN'S REPORT AND CLAIM FOR PERIODIC SCREENING AND RELATED PROCEDURES

SOUTH CAROLINA

- SIX-PART FORM FOR SCREENING AND DIAGNOSIS, PLAN OF TREATMENT AND TREATMENT COMPLETED
- CLIENT INFORMATION SUMMARY
- BLUE CROSS/BLUE SHIELD TREATMENT FORM

WASHINGTON

- EARLY SCREENING AND DIAGNOSIS BILLING FORM
- PHYSICIAN'S INVOICE
- HOSPITAL INVOICE
- MEDICAL VENDOR INVOICE
- RECOMMENDED REFERRAL FORM